

"Case study in physical medicine rheumatology & rehabilitation"

حالات الجروب منذ افتتاحه ٢٢ - ١١ - ٢٠١٥

و حتي ٢٠١٦-٢-٢٠ سيتم تحديثه تباعا ان شاء الله

Case 1

Rageh M. Elsayed

November 22, 2015

بسم الله نبدا حالات تاهيل

REGIONAL PAIN SYNDROME

A CASE OF 34 YS OLD SOCCER PLAYER EXPOSED TO TWISTING TRUMA WHILE PLAYING 3 MONTHS AGO . AFTER MEDICAL CONSULTATION X-RAY FREE AND US OF ANKLE SHOWED PARTIAL TEAR OF ANKLE COLLATERAL LIGAMENT. NSAID AND BKC FOR 2 WEEKS AND REMOVED . PT STARTED PT PROGRAM FOR 2 MONTHS BUT STILL PAIN ,SWELLING AND STIFFNESS IN DORSIFLEXION -10 LIMETED EVERSION-10. PLANTER FLEXION AND INVERSION ARE FREE . SEVERE TENDERNESS OVER LATERAL CUBOID AND ANTERIOR LATERAL TALUS BESIDE DISTAL LATERAL FIBULA AND LATERAL SIDE KNEE . THE PT CAN NOT RUN TILL NOW PLZ FOR DIAGNOSIS AND DISCUSSION ?

المهر الجامح Plain x-ray stress view ..MRI Ankle joint
..Lat.collat.lig repair

المهر الجامح 2 weeks BKC not enough

Rageh M. Elsayed According to orthopedic consultant he decided no need more than 2 weeks .It is partial small tear no

need for repair the problem now is pain swelling stiffness 3 months .

Wajeeh Mahmood persisting pain and swelling >> undiagnosed fracture or intraarticular foreign body >> MRI

Rageh M. Elsayed No fracture

المهر الجامح CRPS

المهر الجامح Complex Regional Pain Syndrome

المهر الجامح Joint stiffness and swelling ,persistent pain ,spread to the leg up to knee

المهر الجامح Type I CRPS

المهر الجامح Pregabalin

Mai Rabie

BkC ممكن اعرف اي اختصار

Rageh M. Elsayed Below knee cast

Rageh M. Elsayed Yes right CRPS instruction although no osteopenia till now medical treatment pregabalin ,nsaid and you may add alendronate and ca

Rageh M. Elsayed What about rehabilitation?

Rageh M. Elsayed Stiffness is the problem when solved edema and pain will subside think in biomechanics of ankle twisting inversion type what will happen in talus ,lower fibula and cuboid bone ?

Tamer Elfarahaty Contrast bath for pain &stiffness

Rageh M. Elsayed The patient was already in pt program for 2 months with different therapeutic modalities with no improvement

Tamer Elfarahaty NCV was done?

Rageh M. Elsayed Not done no weakness it is mechanical block in dorsiflexion

Tamer Elfarahaty No weakness in eversion.?

Rageh M. Elsayed Stiffness -10 degree

Omer Mala Ahmed TENS , US & Laser therapy to decrease pain & oedema

Omer Mala Ahmed Also It is extremely important for patients with RSD to undergo a steady progression from gentle weight bearing to progressive, active weight bearing.

Rageh M. Elsayed

Dear dr analysis of inversion sprain ankle

1-put in mind bone lose its proper articulation with twisting also ligaments can move bone articulation when exposed to sever sprain

2- the key bone in stiffness in dorsiflexion is the talus bone as it moves it moves posteriolly while dorsiflexion in this case the talus moved anteriolateral 3- distal fibula moved anteriorly and neck of fibula moved posteriolly with fixation –

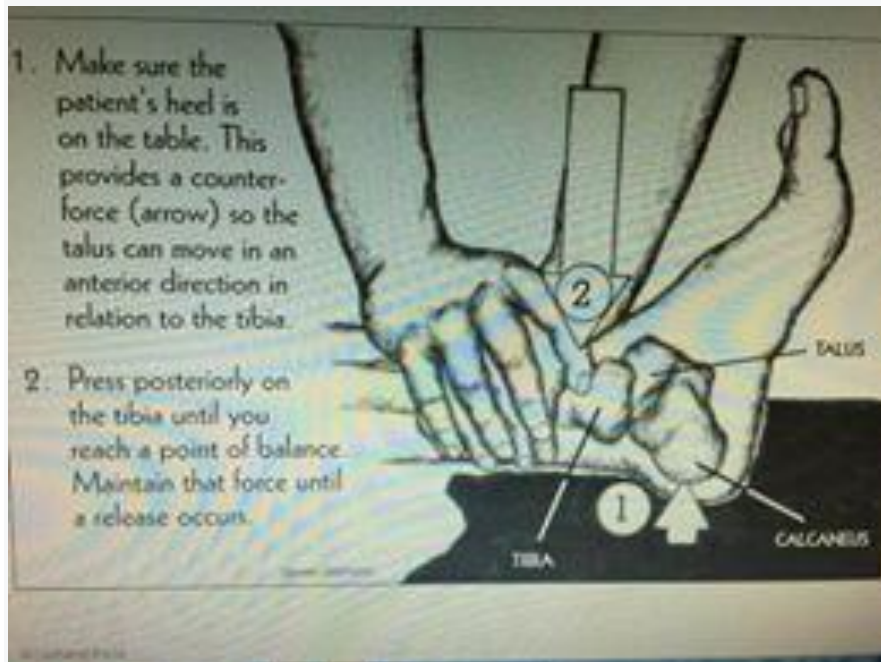
4- cuboid bone can move in anteriolateral direction

Rageh M. Elsayed So our aim is it to correct these mal position of talus fibula and cuboid without this the complain of the patient will continue

Rageh M. Elsayed We have many options either manually or mechanically regarding treatment 1- mobilization of talus to increase dorsiflexion 2- trust technique for talus and cuboid 3- push the lower fibula posterior and in the same time the neck

fibula anteriorly to mobilize the superior tibiofibular joint which will decrease the over stretch on lateral leg muscle

Rageh M. Elsayed



Rageh M. Elsayed You can YouTube posterior talus glide or talus thrust technique will find it very effective within 2 to 3 trials only

Rageh M. Elsayed Mechanical problem treated with mechanical manuevers not chemical

Rageh M. Elsayed Put manipulation and mobilization techniques in each case practice to restore normal joint movement in cases of stiffness

Aliaa Omar El-hady

Posterior Talar Glide

- Indicated for patients with inadequate dorsiflexion range of motion
- Conjunct external rotation of the talus at endrange



Aliaa Omar El-hady

Talocrural Manipulation

- Indicated for patients lacking full dorsiflexion
- High Velocity Low Amplitude Thrust (HVLA) in inferior direction to traction the joint



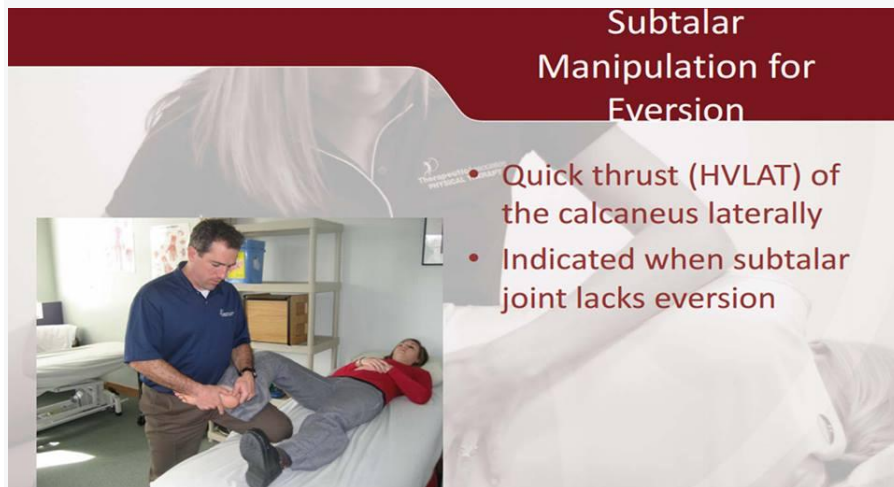
Aliaa Omar El-hady

Calcaneal Lateral Glide

- Indicated when patient lacks full eversion
- Anterior joint is mobilized medially while posterior joint is moved laterally
 - Plane or joint is about 30 degrees anteromedial/posterolateral



Aliaa Omar El-hady



Aliaa Omar El-

IpOE98sAs



TALOCRURAL JOINT POSTERIOR GLIDE TALUS

YOUTUBE.COM

Mohamed Magdy Very nice case

Mohamed Magdy What about use of steroid now in this case
?????

Rageh M. Elsayed NOROLE OF STEROID MECKANICAL
PROBLEM SOLVED BY MECHANICAL METHODS

Sherry Kamel It is very nice discussion, regarding
manipulation, does all therapist can do this manipulation
technique, or it requires special skills?????

Aliaa Omar El-hady

شوفي فيلم الفيديو اللي حطيته في الكومنتات... اعتقد ان الجميع ممكن يعملوه

Rageh M. Elsayed EASY TO LEARN WITH GOOD RESULTS ON THE SPOT

Rageh M. Elsayed see normal alignment of talus regarding navicular bone



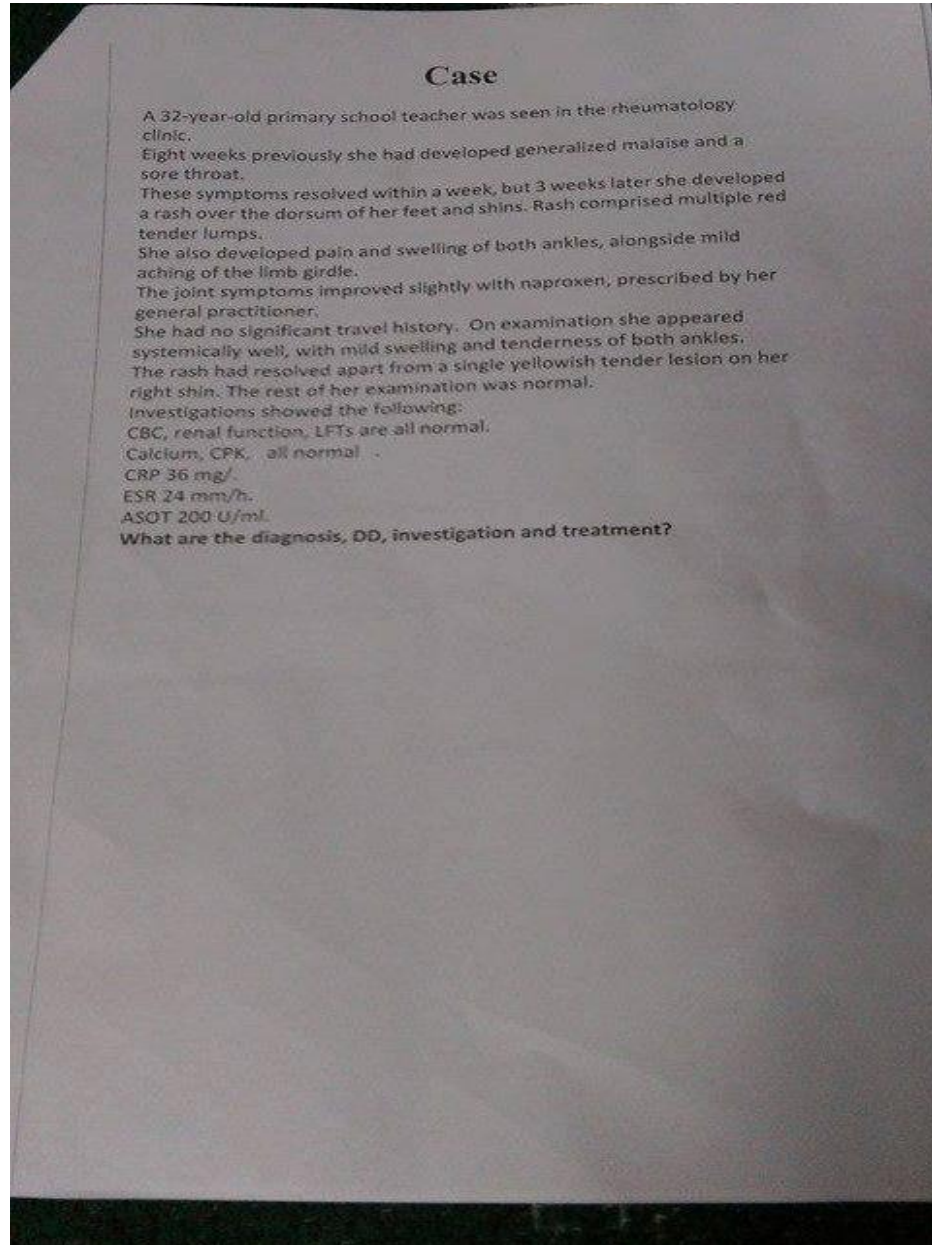
Rageh M. Elsayed see my case talus anterior displaced in relation to navicular this prevent dorsiflexion



Rageh M. Elsayed i will post the x ray after mobilization ISA

Case2

الحالة دي نزلت الدور ده فى امتحان ال commentary وكانت صعبة عليهم
واختلف اللي بيحلها معاهم ولقيت اجابتها فى الكتاب
الوحيد اللي حلها مظبوط هو د. على مرسى Ali Mursi
حالة Sarcoidosis



Case 4

A 32-year-old Caucasian primary school teacher was seen in the rheumatology clinic. Eight weeks previously she had developed generalized malaise and a sore throat. These symptoms resolved within a week, but 3 weeks later she developed a rash over the dorsum of her feet and shins. The rash comprised multiple red tender lumps. She also developed pain and swelling of both ankles, alongside mild aching of the limb girdle. The joint symptoms improved slightly with naproxen, prescribed by her general practitioner. She had no significant travel history.

On examination she appeared systemically well, with mild swelling and tenderness of both ankles. The rash had resolved apart from a single yellowish tender lesion on her right shin. The rest of her examination was normal.

Investigations showed the following:

- FBC, U&Es, LFTs, calcium, CPK, TSH all normal
- CRP 36 mg/L, ESR 24 mm/h
- ASOT 20 U/mL.

The CXR is shown in Fig. 4.1.



Fig. 4.1 Chest X-ray

Questions

1. What is the rash likely to be and what is the differential diagnosis, based on the history and examination findings alone?
2. What is the most likely diagnosis, taking the CXR findings into account?
3. What is a likely explanation for this patient's muscle aches and what are the systemic manifestations of this condition?
4. How would you manage this patient and what is her prognosis?

Answers

1. What is the rash likely to be and what is the differential diagnosis, based on the history and examination findings alone?

The rash is most likely to be due to erythema nodosum. It characteristically develops as an acute nodular erythematous eruption. It is most commonly found on the extensor aspect of the legs and is particularly painful during the first week. As it heals, it changes from red to blue and ultimately resembles a bruise. Individual lesions tend to last for about 2 weeks, but individual crops usually develop in a staggered fashion.

The presence of a sore throat prior to the onset of the joint symptoms raises the possibility of rheumatic fever or a post-streptococcal reactive arthritis (see p. 249). The arthritis of rheumatic fever does usually affect large joints, including the knees and ankles, and usually settles within 1–2 weeks. However, the absence of the typical migratory polyarthritis, whereby several joints are affected in quick succession, each for a brief period of time, makes it unlikely. It would also usually be accompanied by an acute febrile illness. Although it is possible that the nodular rash represents the subcutaneous nodules found in rheumatic fever, these tend to be painless and resolve within a few days. The presentation is not typical for post-streptococcal reactive arthritis either, as it usually develops 2 weeks after the initial throat infection and is often associated with a non-migratory large-joint oligoarthritis which persists for longer than 2 weeks.

Reactive arthritis does commonly affect the ankles and many of the causative organisms, including *Mycoplasma*, *Campylobacter*, and *Salmonella*, are also associated with erythema nodosum. However, there is nothing in this patient's history to suggest a preceding infective illness with these organisms.

Viral arthritis (see p. 246), for example following human parvovirus B19 infection, is another possibility: particularly given that the patient is a primary school teacher. However, the viral arthritides tend to develop during the viral prodrome itself and are usually associated with a symmetrical small-joint polyarthritis, with a predilection for the upper limbs.

Other causes of arthritis or arthralgia in the context of erythema nodosum include enteropathic arthritis (see p. 31), Behçet's disease (BD), lymphoma, tuberculosis, and acute sarcoidosis. Although enteropathic arthritis does usually result in a large-joint oligoarthritis affecting the knees and ankles, this woman does not have any symptoms suggestive of underlying inflammatory bowel disease (IBD). BD (see p. 223) would be uncommon in a Caucasian female, and it is usually associated with orogenital ulceration. Arthritis as the presenting feature of lymphoma in adults is rare, and has been reported more in children. Tuberculosis can spread to affect joints by haematogenous or lymphatic routes, or via contiguous spread from an infected area. This tends to affect the spine and large weight-bearing joints. Alternatively, pulmonary or other organ tuberculosis can cause a reactive polyarthritis known as Poncet's disease. This can affect any joint areas, but knees, ankles, and elbows are the most common. This patient does not have any known risk factors or

symptoms suggestive of tuberculosis. Patients with acute sarcoidosis commonly have joint complaints (50%), with symmetrical ankle involvement being a strong diagnostic indicator.

2. What is the most likely diagnosis, taking the CXR findings into account?

The CXR shows right paratracheal lymphadenopathy with symmetrical bilateral hilar lymphadenopathy. These radiographic findings comprise Garland's triad, which is commonly seen in sarcoidosis with pulmonary involvement. Chest radiograph findings are staged as follows.

- Stage 0: Normal
- Stage 1: Bilateral hilar lymphadenopathy
- Stage 2: Bilateral hilar lymphadenopathy with parenchymal involvement
- Stage 3: Parenchymal involvement with shrinking adenopathy
- Stage 4: Parenchymal involvement evolves to show volume loss.

As there is no parenchymal involvement, this would be consistent with stage 1 disease. Lymphoma is an important differential diagnosis in the context of bilateral hilar lymphadenopathy, and can only be definitively excluded on biopsy.

Therefore the most likely diagnosis is acute sarcoidosis with stage 1 pulmonary involvement.

3. What is a likely explanation for this patient's muscle aches and what are the systemic manifestations of this condition?

Muscle involvement in sarcoidosis is relatively common, occurring in 50–80% of cases. It is usually asymptomatic and so is often undetected. Granulomatous muscle involvement can lead to weakness, proximal pain, and tenderness. This may be focal or diffuse, in which case it is symmetrical and causes progressive weakness and atrophy. Electromyography (EMG) studies show similar findings to polymyositis.

Sarcoidosis is a multisystemic condition of unknown aetiology, characterized by the presence of non-caseating granuloma in affected tissues. The various manifestations are summarized below:

- Lungs (90%):
 - lymphadenopathy
 - parenchymal involvement
 - pleural involvement may manifest as pneumothorax or pleural effusion (rare).
 - Skin (25%):
 - erythema nodosum
 - subcutaneous nodules
 - papules
-

- plaques
- lupus pernio.
- Joints (50%):
 - transient flitting arthralgia can precede fever
 - symmetrical periartthritis
 - knees, ankles.
- Bone (30%):
 - cysts, hands, and feet
 - lytic lesions (rare) in the vertebral bodies, and occasionally in skull, long bones.
- Eyes (25%):
 - keratoconjunctivitis
 - uveitis
 - retinal vasculitis.
- Neurological (5%):
 - unilateral facial nerve palsy
 - hypothalamic–pituitary axis
 - basal granulomatous infiltration
 - peripheral neuropathy.
- Abdominal (50%):
 - hepatosplenomegaly
 - nephrolithiasis due to hypercalcaemia.
- Cardiac (5%):
 - cor pulmonale due to lung disease
 - arrhythmia
 - left ventricular failure
 - pericarditis.

4. How would you manage this patient and what is her prognosis?

The joint symptoms usually improve with a combination of rest and non-steroidal anti-inflammatory drug (NSAID) treatment. In severe cases, steroids or colchicine may be used, but there is little evidence base for this.

Pulmonary involvement is treated according to disease and symptom severity. Steroid therapy is first line in symptomatic disease. Although stage 4 disease represents pulmonary fibrosis, patients usually still derive symptomatic benefit which may be due to suppression of ongoing inflammation. In resistant cases, immunosuppressive agents have been used with variable benefit, but lung transplantation should be considered in those with progressive treatment-resistant disease.

The erythema nodosum usually self-resolves within a few weeks, but topical steroid therapy can be used as required.

Aliaa Omar El-hady

hilar lymphadenopathy
طبعا اللي صعب الحالة انهم ما حطوش الاشعة اللي فيها

Ali Mursi Bilateral ankle arthritis 95% sarcoidosis

Sherry Kamel

...اتحطت كانت الحالة اتعرفت.... plain x-ray

Aliaa Omar El-hady

diagnosis... طبعا بشيلها ضاع جزئية مهمة من ال

Case 3

Case study with its solution (1)

History of Present Illness:

The patient is a 40-year-old man and is a dedicated long distance runner. He had a 1-year history of right ankle arthralgias and a 2-month history of right knee arthralgias. Then, during a meeting he was attending in the U.S., he developed right thigh, calf & foot swelling, and a right knee effusion.

Evaluation yielded the following:

Laboratory findings:

- ESR 40 mm/hr
- normal CBC, differential & uric acid

Right leg venous Doppler – negative for DVT

Right knee MRI – positive for a ruptured Bakers cyst

Subsequent evaluation included:

Orthopedics consultation x 4

Rheumatology consultation x 1

Emergency Department evaluation x 1

These evaluations revealed the following:

Laboratory findings – normal comprehensive metabolic profile, ESR, urinalysis, and Lyme ELISA & Western blot

Arthrocentesis x 3 (representative values):

WBC – 10,683/mm³

Differential – 79% neutrophils and 21% mononuclear cells

Crystals – none

Bacterial culture – negative

Right leg venous Doppler – positive for a Bakers cyst

Abdomino-pelvic CT scan – normal

Pharmacologic interventions:

Celecoxib, indomethacin & nabumetone

Tramadol

Hydrocodone/APAP

Doxycycline

Intra-articular corticosteroids

Presentation to Rheumatology Clinic

He had persistent right leg swelling but the effusion in his right knee had resolved. He had a new effusion in his left knee and had developed arthralgias in the left ankle.

Past Medical History, Family History & Social History – unremarkable

Review of Systems:

Rash or psoriasis – none

Ocular inflammation – none

Cough or dyspnea – none

Cramping, diarrhea, hematochezia or mucous stool – none

Dysuria or genital lesions – none

Low back pain – present

Low back stiffness – none

Tick exposure – none

Physical Examination

Cutaneous:

Right 4th and 5th fingernails – isolated “pitting”

Psoriatic plaques – none

Oral mucosa – no lesions

Eyes – no inflammation

Chest – clear

Gastrointestinal:

Abdomen – benign

Stool Hemoccult – positive

Peripheral articular:

Right knee synovitis – none

Left knee synovitis – present

Left ankle synovitis – none

Axial articular:

Sacro-iliac joint tenderness – none

Schober test – 4 cm lumbar distraction

Differential Diagnosis

- [] Trauma
- [] Microcrystalline arthritis
- [] Septic/viral arthritis
- [] Lyme disease
- [] Rheumatoid arthritis
- [] Sarcoidosis
- [] Sero-negative spondyloarthropathy

Additional Diagnostic Studies

CBC & differential – normal
Rheumatoid factor – negative
Lyme serology – negative
Parvovirus serology – negative
Chest x-ray – normal
Sacro-iliac joint x-ray – normal

This narrowed the differential diagnosis to a sero-negative spondyloarthropathy.

Possibilities included:

Ankylosing spondylitis
Inflammatory bowel disease
Psoriatic arthritis
Reiters syndrome

Further evaluation revealed:

History – “Dandruff” x 3 months

Examination

- Scaling plaque right occiput
- Dactylitis right 3rd toe

EGD & colonoscopy with biopsy – normal

Dermatology consult with biopsy – Psoriasis

Subsequent Course

These pharmacologic interventions were initiated sequentially, in combination with physical therapy:

NSAIDs

Intra-articular corticosteroid injection

Methotrexate (7.5 mg-15 mg weekly) x 5 months

Etanercept (25 mg SQ b.i.w.)

He had a dramatic clinical response in all respects except for persistent and diffuse right leg swelling.

Summary of Teaching Points

The cutaneous manifestations of psoriatic arthritis may be scant or non-existent and need to be looked for carefully on examination.

Nail pitting and dactylitis, while not specific, are highly suggestive of psoriatic arthritis.

The patterns of joint involvement in psoriatic arthritis are variable.



Case 4



Omer Mala Ahmed

October 19, 2014 · Rania, Iraq

27 years old female with skin thickening proximal to the elbows and knees in addition to distal extremity involvement (diffuse SSc) , Hand & feet Raynauds phenomenon , Inflammatory synovitis of the peripheral joints, particularly those of the hands and wrists.

🔴 Investigations:

- ☐ CBC Normal
- ☐ ESR 56
- ☐ CRP Strongly +ve
- ☐ GUE Normal
- ☐ Renal Function Normal
- ☐ Liver function Normal

🔴 SEROLOGY:

- 🔴 ANA -ve
- 🔴 Anti dsDNA -ve
- 🔴 RF -ve
- 🔴 Anti CCP -ve
- 🔴 Anti SM -ve
- 🔴 Anti Ro & La -ve
- 🔴 Anti Scl70 -ve
- 🔴 Anti Centromere -ve

🟢 CT Chest:

bibasilar pulmonary fibrosis.

🟢 Echo cardiography Normal

🏠 how you manage this patient with Diffuse SSc + Pulmonary fibrosis & Arthritis ?







Abdallah El-Sayed Allam What about thyroid function tests and HCV?

October 19, 2014 at 9:33pm · Like



Abdallah El-Sayed Allam MMF+HQ+Vit D+Statins

October 19, 2014 at 9:34pm · Like · 2



Waleed Salah what is the pattern of fibrosis in ct is it ground glass or honey comb

October 19, 2014 at 9:52pm · Like



Omer Mala Ahmed Dear dr Waleed Salah its written in report mild sub plural fibrosis

October 19, 2014 at 9:55pm · Like



Omer Mala Ahmed Dear Dr Abdallah El-Sayed Allam thanks alot , thyroid function normal & viral screening negative , do you think this patient need pulse Cyclophosphamide? Why HCQ ?

October 19, 2014 at 9:57pm · Like · 2



Abdallah El-Sayed Allam For arthritis,,, i think no need now,, MMF starting with 500mg twice daily---->up to 3 gm /day according to patient tolerance or response of the disease

October 19, 2014 at 10:01pm · Like · 2



Waleed Salah this type of pulmonary fibrosis (subpleural fibrosis) is found mainly in usual interstitial pneumonitis(UIP) which is usually not responding to immunosuppressive so no need for pulse cyclophosphamide

October 19, 2014 at 10:05pm · Like · 2



Sherry Kamel for pulmonary fibrosis :Endoxan pulse 750mg monthly+ 500mg steroid if IF is ground glass appearance on CT chest (acute lesion).... for 6 months then maintenance AZA / cell cept ,,,,,,pulse Cyclophosphamide has been shown to improve skin thickening,pulmonary fibrosis, stabilize pulmonary function..... low dose corticosteroids (<10 mg/day) may also have some value for the symptomatic treatment of inflammatory arthritis calcium channel blockers, usually oral nifedipine, should be considered for first-line therapy for SSc-related RP).

October 19, 2014 at 10:16pm · Edited · Like · 2



Waleed Salah what about raynauds

October 19, 2014 at 10:17pm · Like



Waleed Salah for arthritis : 1st be sure that no overlap syndrome as frank arthritis is not so common in SSC

October 19, 2014 at 10:18pm · Like



Waleed Salah 2nd give NSAIDS and for immunosuppression you have 2 options MMF as Dr Abdallah mentioned or MTX but have prior pulmonary function test and close follow up

October 19, 2014 at 10:20pm · Like



Abdallah El-Sayed Allam Statins 40 mg/d for raynaud's

October 19, 2014 at 10:29pm · Like



Omer Mala Ahmed I started treatment of this patient with Immuran + low dose prednisolone 10mg/day + Nifedipine 10 mg/night + VitD & Calcium .

I did followup for this patient for the last 6 months & she is very ok regarding Arthritis , skin tightness & Raynauds .

Dear Dr Abdallah El-Sayed Allam & Dr Waleed Salah your advice to shift to another Drug? Can we use MTX in patients with SSc & Pulm Fibrosis ?

October 19, 2014 at 10:32pm · Like · 1



Waleed Salah this is new for me Abdallah , we usually give calcium channel blocker as 1st line and in resistant cases we give sildenafil or prostaglandin analogues, is this new option??

October 19, 2014 at 10:32pm · Like · 2



Omer Mala Ahmed Thanks Dr Sherry Kamel for your good comment

October 19, 2014 at 10:34pm · Like · 1



Abdallah El-Sayed Allam hit the disease aggressively and i hate use of low dose steroids in such cases

October 19, 2014 at 10:34pm · Like · 1



Waleed Salah dear dr omer , for immuran you usually will not give benefit for joints or lung as shown in many studies

October 19, 2014 at 10:35pm · Like · 3



Waleed Salah i agree with dr abdallah that steroid is not preferred in such cases

October 19, 2014 at 10:36pm · Like · 1



Abdallah El-Sayed Allam

د وليد باشا فى بحثين اتعملوا على دور ال statins واحد اتعمل فى طب
اسكندريه اظن بروفيسور أن ابو ريا هى اللى عامله والثانى فى اليابان اذا
لم تخنى الذاكرة

October 19, 2014 at 10:37pm · Like · 1



Waleed Salah for immunosuppressive of course MMF is the best but if the pt can afford but this minimal fibrosis is not contraindication for MTX but have close follow up with baseline PFT

October 19, 2014 at 10:38pm · Like · 2



Omer Mala Ahmed Youvare right dear Dr Waleed Salah , i just saw benefit of immuran in vasculitis & lupus nephritis , i will change this drug , but my question; can we use MTX in such cases with pulm fibrosis? As you know MTX is very good for such arthritis , MTX could be beneficial for skin changes?

October 19, 2014 at 10:39pm · Like · 1



Abdallah El-Sayed Allam I think MTX is of no benefit

October 19, 2014 at 10:40pm · Like



Waleed Salah for the dilemma of pulmonary fibrosis and when to consider it we have 2 main types:

October 19, 2014 at 10:40pm · Like



Omer Mala Ahmed Dear dr Abdallah El-Sayed Allam you mean not using steroid at all ? Even as Bridge therapy till MMF work ?

October 19, 2014 at 10:41pm · Like · 1



Waleed Salah 1. Nonspecific interstitial pneumonitis (NSIP) which appear like ground glass appearance that usually respond to intense immunosuppression best cyclophosphamide

October 19, 2014 at 10:41pm · Like · 3



Waleed Salah 2. usual interstitial pneumonitis that is immunosuppressive non responder and appear as honey comb appearance or subpleural fibrosis

October 19, 2014 at 10:54pm · Edited · Like · 1



Waleed Salah

but you think it is given with or instead of calcium channel blockers
منك نستفيد يا د عبدالله

October 19, 2014 at 10:46pm · Like · 1



Abdallah El-Sayed Allam BRIDGE THERAPY,, WHY?

October 19, 2014 at 10:47pm · Like



Abdallah El-Sayed Allam

VASCULAR PATHOLOGY AND SKIN FIBROSIS WITH MODULATION OF IMMUNE CELLS
بتحسن ال

October 19, 2014 at 10:49pm · Like



Abdallah El-Sayed Allam

بدل ال CCB

October 19, 2014 at 10:49pm · Like · 1



Omer Mala Ahmed Dear dr Waleed Salah in both sub types you said it appear as Ground glass appearance! How we can separate these two sub types? If the 2nd subtype not respond to immunosuppressive drugs how manage it?

October 19, 2014 at 10:50pm · Like



Waleed Salah it is mentioned in oxford textbook of rheumatology that pul fiosis is not absolute c.i for MTX but need close follow up but of course i will be more worried if more extensive fibrosis

October 19, 2014 at 10:50pm · Like · 1



Abdallah El-Sayed Allam better to prevent by early diagnosis and aggressive ttt

October 19, 2014 at 10:53pm · Like · 1



Waleed Salah in 2nd type usual interstitial pneumonitis (uip) that is immunosuppressive non responder and appear as honey comb appearance or subpleural fibrosis

October 19, 2014 at 10:53pm · Like · 1



Omer Mala Ahmed Dr Abdallah El-Sayed Allam the patient presented to me with arthritis & edematous hands , dramatically responded to this small dose steroid , as you know other DMARDs & Immunosuppressive drugs need time to give there effect (thats why i said bridge therapy) , are you with use of Pulse Cp in this patient?

October 19, 2014 at 10:54pm · Like · 1



Waleed Salah sorry i corrected it

October 19, 2014 at 10:54pm · Like · 1



Waleed Salah no problem but we usually worry about scleroderma renal crisis

October 19, 2014 at 10:56pm · Like · 2



Waleed Salah and usually we worry about low doses more than large doses

October 19, 2014 at 10:57pm · Like · 2



Waleed Salah and usually we worry about low doses more than large doses

October 19, 2014 at 10:57pm · Like · 2



Omer Mala Ahmed Dr Waleed Salah yes you are right for risk of steroid therapy , you advice to avoid steroid in cases of Scleroderma? How you manage The 2nd sub type of pulm fibrosis ?

October 19, 2014 at 11:00pm · Like · 1



Waleed Salah yes i usually try to avoid steroids except in cases like ground glass appearance and even in such condition i give cyclophosphamide although some expert prefer to choose according to thr result of BAL

October 19, 2014 at 11:04pm · Like · 1



Waleed Salah for 2nd type it usuaaly apoblem as no drug can reverse fibrosis but some encouraging data about gamma interferon but i have no experience about it but no need to expose the patient to the hazards of intense immunosupression and for minimal subpleual fibrosis i think immunosuppressant taken for arthritis(MMF or MTX) can help with follow up

October 19, 2014 at 11:09pm · Like · 1



Hala El Hadary Thanks prof omer for this interesting cases and very interesting discussions between all those imminent doctors

Regarding your patient I noticed that she has like gotterans sign on the knuckles !! What about the CPK and the RNP ?

I respect all the previous opinions but in a patient 27 years old I have to know first is she's married or not and does she has children or not before starting endoxan
You managed the case in A very proper way as there was no signs of active pulmonary fibrosis like dyspnea
The mantainance therapy is important now
You have several options



Waleed Salah and usually we worry about low doses more than large doses

October 19, 2014 at 10:57pm · Like · 👍 2



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Hala El Hadary Thanks prof omer for this interesting cases and very interesting discussions between all those imminent doctors

Regarding your patient I noticed that she has like gotterans sign on the knuckles !! What about the CPK and the RNP ?

I respect all the previous opinions but in a patient 27 years old I have to know first is she's married or not and does she has children or not before starting endoxan

You managed the case in A very proper way as there was no signs of active pulmonary fibrosis like dyspnea

The mantainance therapy is important now

You have several options

You have several options

- 1) stay on the immuran + small dose steroids + calcium channel blocker + HCQ
- 2) shift to more potent drug as cellcept instead of the immuran if she can afford (trials approved more stronger action)
- 3) endoxan if the lung condition started to deteriorate by serial CT CHEST + PFT) after 3 or 6 months
- 4) you can also consider rituximab 500 mg pulse every 6 months in addition to any of the previous therapy line

Best regards and hope your patient get well soon

October 19, 2014 at 11:12pm · Like · 6



Omer Mala Ahmed Thanku & thanku very much Dear Dr Waleed Salah & Dr Abdallah El-Sayed Allam for your precipitation in this case discussion

October 19, 2014 at 11:13pm · Like · 2



Omer Mala Ahmed Hot greetings dr Hala El Hadary , thanks for your participation in this case discussion , she has normal CPK , RNP not done , no evidence of muscle weakness , these patchy red areas over the joints are due to cold weather & part of Raynauds (today here is cold with heavy rain)

She is married & has 2 children & has no plan for further pregnancy .

Do you think that immuran is beneficial? I plan to stop it & shift to MMF .

Yes you sre right Retuximab is very useful for skin & lung , but unfortunately at this time not available in our hospital

October 19, 2014 at 11:22pm · Like · 2



Hala El Hadary If she can afford the cellcept of course it's more potent than the immuran and has almost same results as the endoxan shift and keep the small dose steroids , HCO , ca channel blocker , sildenafil , vit D , proton pump inhibitors , calcium , Vaseline for the skin and instructions to avoid smoking , cold , and use gloves



Omer Mala Ahmed Dr Hala El Hadary the problem in this case is usually says i can not take all these Drugs! So i will shift To MMF + small dose steroid + Adalat + Vit D& Ca . Do you think HCQ is necessary in this case ? MMF is not enough ? MMF is also not helpful for arthritis?

October 19, 2014 at 11:43pm · Like · 1



Tamer Farahaty Colchicine & artamine may be helpful in combined arthritis and skin lesion .cellcept for pulmonary fibrosis. Nifedipine 20 mg for RP plus Vit D , Ca , low dose of sretoid and avoid NSAIDs.

October 20, 2014 at 12:05am · Edited · Like · 1



Howaida Elsayed Mansour This patient has a scleroderma vs overlape syndrome as there are gottrons papules in spite of -ve ANA !! did you do ANA by indirect immunofluorescence technique as it is very strange for the scleroderma patient to be ANA negative also anti U1 RNP (mixed CT) but the most important thing is 1- to start cyclic monthly pulse soluomedrol + Endoxan as fast as you can

....
Sp.if you have pulmonary fibrosis even if it is very mild and early please be step ahead of this aggressive illness ..dont wait for the illness to be more advanced. 2- Pulse therapy will minimize the oral ttt and keep her on 10 - 15 mg oral steroids + delaytiazem + check for hypertension and calcid 500 (Ca + vit D)

October 20, 2014 at 5:49pm · Edited · Like · 3



Howaida Elsayed Mansour 1- No need for the HCQ except if the arthritis persist or the appearance of butterfly rash..

2- Dont be afraid of scl renal crisis with the pulse steroids when combined with Endoxan for 6 -8 mobths

October 20, 2014 at 2:03am · Edited · Like · 4



Omer Mala Ahmed Thanku alot dr Howaida Elsayed Mansour for your nice informative comments , i did ANA by ELISA & I will redo it by IFT , but the CT report said that there is sub plural fibrosis (usual interstitial pneumonitis that appear as sub plural fibrosis or Honeycomb appearance) which is immunosuppressive non responder as dr Waleed Salah said , the only type of pulmonary involvement that respond to immunosuppressive therapy(Cyclo & Steroid) is (non specific interstitial pneumonitis) which is appear as Ground glass appearance on CT chest
October 20, 2014 at 9:48am · Like · 1



Omer Mala Ahmed Dear Dr Waleed Salah why some doctors prescribe colchicine ? D-penicillamine useful in SSc or not ?thanks
October 20, 2014 at 10:48am · Edited · Like



Omer Mala Ahmed Dr Heba Abdl El Wahab why some doctors prescribe colchicine for SSc ?D-penicillamine useful in SSc or not ? thanks
October 20, 2014 at 10:48am · Like



Howaida Elsayed Mansour Dont relay much on the CT report in choosing the immunosuppressive regimen ... We shall start this regimen not only for the pulmonary lesion but for induction of remission of such aggressive disease ,in many instances both types of interstitial pnemonitis coexist soon this patient might have pulmonary hypertension , and advanced skin score.. So dont wait for this we should run....!
October 20, 2014 at 5:45pm · Like · 3



Howaida Elsayed Mansour No role for colchicine or D-penicillamine in recent ttt guidelines of Scleroderma. .
October 20, 2014 at 5:52pm · Like · 3



Waleed Salah actually as dr howaida said they are old treatment with many side effects however i tried both in many patients in the past and i found no result with colchicine and partial response (regarding skin) with d penicillamine in some patients

October 20, 2014 at 10:38pm · Like · 2



Waleed Salah for lung i suggest to do close follow up including PFTs

October 20, 2014 at 10:40pm · Like



Abdallah El-Sayed Allam once patient diagnosed Ssc with mild skin aff and or other manifest. you must start aggressive immune suppression, plz deal with it as malignant tumor

October 20, 2014 at 10:45pm · Edited · Like · 3



Omer Mala Ahmed Thanks for all in this nice case discussion

October 20, 2014 at 11:37pm · Like · 1



Howaida Elsayed Mansour Thank you very much dr Omar for sharing us these interesting cases and discussions...

October 21, 2014 at 12:46am · Like · 3



Omer Mala Ahmed Dear Dr Waleed Salah are you agree with using pulse steroid in combination with pulse Cyclo for Mx of SSc associated pulmonary fibrosis ? Or just pulse Cyclo is enough ? And are you agree with using continuous small dose steroid 10mg/day after pulse therapies ?

October 22, 2014 at 1:29pm · Like · 1



Waleed Salah for me i usually use pulse cyclophosphamide i think it is superior and have longlasting effect than steroids also i donot prefer steroids in patients with SSC except if it is a must and in case of ssc lung disease we have efficient alternative, however some experts prefer to choose according to predominant cell type in bronchoalveolar lavage if lymphocytes-----steroid if PMNL-----cyclophosphamide

October 22, 2014 at 3:59pm · Like · 1



Basant Esawy Uptodate

Active disease — Signs of active (ie, progressive) disease include an early disease stage, abnormal and/or declining pulmonary function, and possibly ground glass opacity on high resolution computed tomography (HRCT).

October 23, 2014 at 8:11pm · Like · 1



Basant Esawy Once the decision has been made to initiate therapy, we advocate intravenous monthly cyclophosphamide together with low dose oral glucocorticoids (equivalent of prednisone ≤ 10 mg/day). Liberal fluid intake is encouraged during therapy. Azathioprine plus glucocorticoid is an alternative regimen that can be considered for patients with contraindications to cyclophosphamide or who decline cyclophosphamide

October 23, 2014 at 8:11pm · Like



Basant Esawy We avoid combining high dose glucocorticoids with cyclophosphamide because of the lack of clinical trial data and the attendant risks of scleroderma renal crisis and immunosuppression. One observational series described a short-term benefit to high dose compared with low dose glucocorticoids in patients receiving cyclophosphamide for SSc-related ILD, but this has not been our experience [30].

October 23, 2014 at 8:12pm · Like · 1



Basant Esawy Larger, randomized investigations are needed before implementing MMF in the routine treatment of SSc-ILD

October 23, 2014 at 8:12pm · Like · 1



Basant Esawy The role of rituximab in the treatment of ILD associated with SSc will require further study in a larger trial of longer duration.

October 23, 2014 at 8:13pm · Like · 1



Basant Esawy All from Uptodate

October 23, 2014 at 8:13pm · Like · 2



Omer Mala Ahmed Dr Basant Esawy are you prefer longvterm small dose steroid for SSc (<10 mg) ?

October 23, 2014 at 11:09pm · Like · 1



Basant Esawy For me I do not prefer long term steroid as soon as the joint and chest symptoms improved steroid tapered to as minimal as pt tolerate to avoid renal crisis till no steroid at all

October 24, 2014 at 7:08am · Like · 1



Omer Mala Ahmed

October 18, 2014 · Rania, Iraq · Edited

25 years old 2 miss period pregnant patient , primigravida (G1P0A0) , few months ago presented to me with Rt.lower limb pain & swelling 🚑

INVESTIGATIONS:

- ▮ Doppler U/S :extensive Right side lower limb DVT (involving femoral & popliteal Veins)

- ▮ Anti cardiolipin (-ve)

- ▮ Lupus anti Coagulant (POSITIVE)

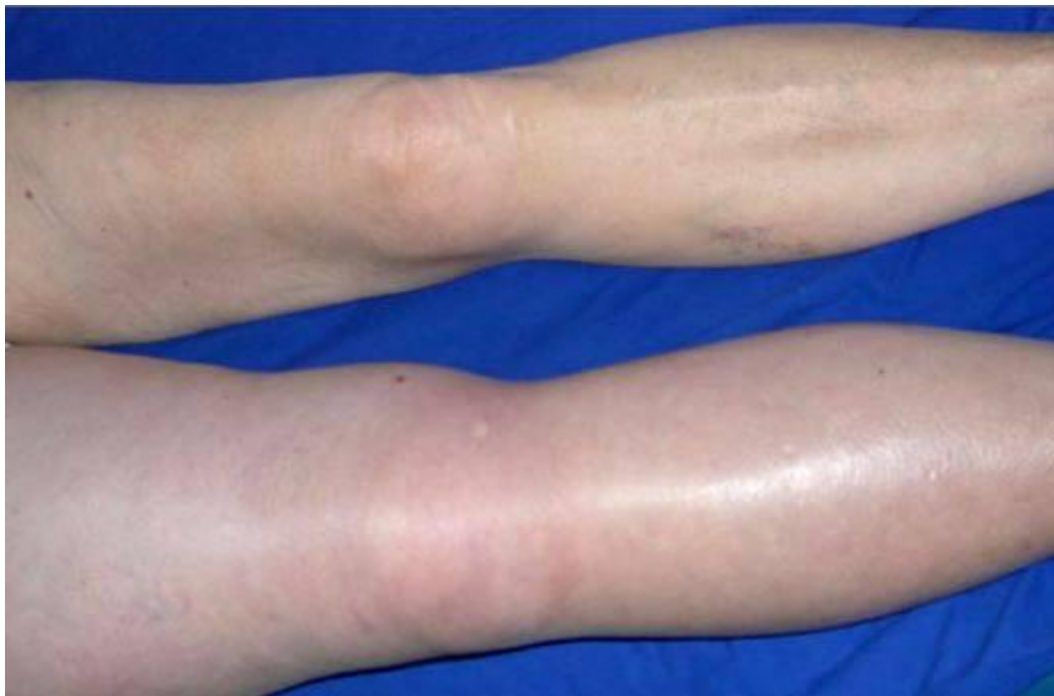
- ▮ Beta2 GP (-ve)

👩 i managed this patient as a case of APL syndrome with LMW Heparin & 100 mg Aspirin / day with regular Doppler examination for the mother & fetus .

- ▮ fortunately yesterday she delivered a Normal baby with NVD

👩 Consultation:

HOW YOU MANAGE THIS PATIENT IN POST PARTUM PERIOD & FOR HOW LONG SHE NEED ANTI COAGULATION THERAPY?





Eman Baraka Anti coagulation for life continue heparin post partum then change to oral anticoagulant.

October 18, 2014 at 10:10pm · Like · 5



Omer Mala Ahmed Dear Dr Eman Baraka thanks for your comment , why for life? Is there Guide lines? Thanks

October 18, 2014 at 10:17pm · Like · 1



Barakat AL-Zaben DVT (involving femoral & popliteal Artery) u mean vein

October 18, 2014 at 10:38pm · Like



Omer Mala Ahmed Dear Dr Barakat AL-Zaben sorry , i mean Veins

October 18, 2014 at 10:54pm · Like · 1



Eman Baraka Dr omer I remember that once there is vascular accidents in Apl syndrome It needs anticoagulant for life .i will search about the guidelines and send for you

October 18, 2014 at 11:04pm · Like · 3



Sherry Kamel Antithrombotic coverage of the postpartum period is recommended in all women with APS, with or without prior thrombosis. Those with previous thrombosis would need long-term anticoagulation, and we prefer switching the patient to warfarin, as soon as she is clinically stable after delivery. the recommendation is for prophylactic dose unfractionated heparin or LMWH therapy for 4-6 weeks after delivery. Both heparin and warfarin are safe for nursing mothers. As pregnancy, heparin, and breastfeeding can all reduce bone mineral density, taking additional calcium 1000mg and vitamin D 800 IU daily can lower the occurrence of osteoporosis

October 18, 2014 at 11:14pm · Like · 5



Eman Baraka <https://www.rheumatology.org/.../Antiph.>

October 18, 2014 at 11:16pm · Like · 2



Sherry Kamel after the postpartum 3 month , you can maintain ur patients low dose aspirin , provided that INR is maintained between 2-3

October 18, 2014 at 11:43pm · Edited · Like · 4



Mohammed Hassan Patients with a history of thrombosis receive therapeutic doses of heparin during pregnancy; long-term anticoagulation is then continued postpartum. with prophylactic calcium and vitamin D

October 18, 2014 at 11:39pm · Like · 2



Mohammed Hassan <http://emedicine.medscape.com/article/333221-treatment#1>

October 18, 2014 at 11:39pm · Like · 1



Waleed Salah patient with vascular event continue on prolonged anticoagulation because unlike many other causes of DVT she has high risk of 2nd attack and you donot know when and where
October 18, 2014 at 11:48pm · Like · 4



Waleed Salah and it is recommended as mentioned by colleagues to have prophylaxis against osteoporosis
October 18, 2014 at 11:50pm · Like · 3



El Sayed Rageh Treatment of the antiphospholipid syndrome - UpToDate
www.uptodate.com/.../treatment-of-the-a...

Jun 11, 2014 - The antiphospholipid antibody syndrome (APS) is defined by two major ... Clinical outcome and cost of hospital vs home treatment of proximal deep vein thrombosis with a ...

October 18, 2014 at 11:53pm · Like · 1



Marwa Aboelhawa Life long anticoagulant therapy with INR 2.5
October 19, 2014 at 1:09am · Like · 1



Omer Mala Ahmed Dr Eman Baraka thanku very much for your comment but i can not look the site that you sent because iam not ACR member , if you can open the site by your self & then copy & paste as a comment so as to see it , thanku alot for your opinion
October 19, 2014 at 10:34am · Like · 1



Omer Mala Ahmed Mohammed Hassan thanku alot
October 19, 2014 at 10:35am · Like · 1



Omer Mala Ahmed El El Sayed Rageh i can not open the link you sent (upto date) because i have no username & password , if you can copy & paste the information in the comment , thanku alot for your information
October 19, 2014 at 10:37am · Like



Omer Mala Ahmed Mohammed Hassan thanku alot

October 19, 2014 at 10:35am · Like · 1



Omer Mala Ahmed El El Sayed Rageh i can not open the link you sent (upto date) because i have no username & password , if you can copy & paste the information in the comment , thanku alot for your information

October 19, 2014 at 10:37am · Like



Omer Mala Ahmed Dr Mohammed Hassan is there a guide line supporting youre comment? Please can you post it , best regards

October 19, 2014 at 10:42am · Like



El Sayed Rageh DEAR BROTHER PLZ SEND E MAIL TO SEND CANNOT SEND BY FACE

October 19, 2014 at 11:00am · Like



Omer Mala Ahmed Thanks alot dear Dr El El Sayed Rageh , this is my Email : dr.omerahmed@ yahoo.com



Yahoo

A new welcome to Yahoo. The new Yahoo...

YAHOO.COM

October 19, 2014 at 12:35pm · Like



Howaida Elsayed Mansour She needs life long anticoagulation by oral anticoagulant, continue on oral anticagulation by marivan 5 mg daily, keep the INR around 2 - 2.5, just check for ANA and DNA as there is 20% possibility for lupus transformation....

October 19, 2014 at 1:16pm · Like · 5



Howaida Elsayed Mansour What about your previous case, the young boy with lupus like rash?

October 19, 2014 at 1:17pm · Like



Omer Mala Ahmed Dr Howaida Elsayed Mansour you speak about the child? Suspected juvenile Dermato myositis ? I arranged for the skin & muscle biopsy & i will post the results inshallah

October 19, 2014 at 1:23pm · Like · 1



Omer Mala Ahmed Thanks Dr Howaida Elsayed Mansour for youre comment , do you have guide lines for managing APL syndrome & DVT ? If you plz post it thankfully

October 19, 2014 at 1:25pm · Like · 2



Talat Elsayed marevan for at least 1y and prohebit pregnancy for next few years then reasses

October 19, 2014 at 9:13pm · Like · 1



Sherry Kamel I review EULAR guide line treatment of APS & pregnancy, what mention that , if you have pregnant APS with DVT ...give LMW heparin for 6-12 week then shift to oral anticoagulant for long period (not for long life).....BUT according to ACR cardiology guidelinetreatment of acute DVT with presence of risk factor (like lupus anticoagulant ABs) give oral anticoagulant for life+low dose aspirine

October 19, 2014 at 9:53pm · Edited · Like · 3



Omer Mala Ahmed Thanka dear Dr Sherry Kamel for your comment , so long period means how long as you think? You prefere which guide line according to your experience ?

October 19, 2014 at 11:56pm · Like



Sherry Kamel I think ,long period means 1 year at least...your case had massive venous thrombosis (femoral &popliteal) so better to follow the ACR cardiology guideline and give your patient LMW heparin fore 6 week then Mervan 5 mg / day for life , provided that her INR 2.5-3..+ calcium , vitamin D and regular follow up to find out any new signs of APS.....

October 20, 2014 at 12:11am · Like · 2



Sherry Kamel thanks dr Omer Mala Ahmedr for sharing all these interesting cases with us



October 20, 2014 at 12:15am · Edited · Like · 2



Omer Mala Ahmed Thanku alot dr Sherry Kamel for your participation in these case discussions with your nice & important comments

October 20, 2014 at 12:46pm · Like · 1

Case 6

☞Case : Enbrel injection site reaction (ISR)

16 years old girl case of eJIA , with bilateral Sacroiliitis , after failure of NSAIDS to improve her symptoms we shifted to Enbrel 50mg/Wk , on first injection had no problem, but on 2nd & 3rd injections in Right & left arms consequently she developed severe pain, diffuse arm swelling & redness involving all the arms . That made the patient unable to use the injected limbs , the condition lasted in every time about 3 days before it resolve spontaneously.

▣I decided to shift the injection site to abdomen because even if it cause ISR it's not cause limb movement limitation so it make less discomfort .

▣I advised the patient to massage the area of injection with ice

▣I prescribed for the patient antihistamine but unfortunately the patient not took the Antihistamine drug & so she developed again an ISR in abdomen .

▣I prescribed Naproxen 250mg *2 to decrease pain & inflammation of ISR .

▣NOTE :

▣Injection site reactions to etanercept usually occur within the first month of treatment. They most commonly occur 1 to 2 days after an injection, and the duration is usually 3 to 5 days. ISRs decrease in frequency with continued treatment in the vast majority of patients, although a persistent or worsening reaction has been described.

▣Most ISRs resolve without treatment, but symptomatic eruptions can be treated with cold compresses, topical corticosteroids, oral antihistamines, or acetaminophen.

Discontinuing treatment with etanercept is rarely indicated.

▣Instruct patients to avoid administering etanercept to the area of ISR. Future injections should be given at least one inch from the periphery of the ISR. Rotation of injection sites should also be encouraged.

▣Instruct patients to avoid administering etanercept to the area of ISR. Future injections should be given at least one inch from

the periphery of the ISR. Rotation of injection sites should also be encouraged.



Tamer Elfarahaty Enprel has fewer side reaction in comparsion to other antiTNf . Yes no need to discontinue it . I think this reaction decrease with time. U can add topical ccs .

Nashwa ElShaarawy Dear de. Omar Try again anti-histaminic next time before injection until reaction resolve

Case 7

Aliaa Omar El-hady

November 24, 2015

Case study with its solution: حالات امتحانات ال commentary

A 76-year-old retired general practitioner presented to the rheumatology department with polyarthritis which had developed insidiously over the previous 18 months. He was a lifelong asthmatic with a 10-year history of hypertension, a heavy smoker, and a heavy social drinker. He took diclofenac, enalapril, and prednisolone 5 mg daily, and used salbutamol and beclometasone inhalers. He admitted to self-medicating with oral steroids for most of his life to control his chest symptoms.

On examination, he was in atrial fibrillation and had a barrel-shaped chest. He had bilateral swelling of his MCP joints, a left knee effusion, a right olecranon bursa, Dupuytren's contractures, and signs consistent with right carpal tunnel syndrome.

Investigations showed the following:

- ◆ Hb 16 g/L; WCC 7×10^9 /L; platelets 232×10^9 /L
 - ◆ Liver function normal; creatinine $135 \mu\text{mol/L}$; glomerular filtration rate (GFR) 55; fasting glucose 5.5 mmol/L; urate 642 mmol/L
 - ◆ CRP 10; RF latex screen positive; ELISA equivocal; anticitrullinated C-peptide (ACCP) negative.
-

Questions

1. What is the likely diagnosis and why?
2. Aspirate from the knee helped confirm the diagnosis. What are the likely

findings?

3. What is the significance of the rheumatoid factor and uric acid levels?

4. What are the clinical manifestations of hyperuricaemia?

5. What management strategies will you suggest?

Answers

1. What is the likely diagnosis and why?

The most likely diagnosis is chronic gout.

The differential diagnosis is between an acute inflammatory arthritis such as rheumatoid arthritis and chronic gout. The radiograph (Fig. 5.1) shows asymmetrical swelling with 'punched-out' erosions away from the joint surface with no osteopenia.

The long-term steroid use is likely to have masked early episodic attacks of gout. Gout often affects osteoarthritic joints. Tophi over Heberden's or Bouchard's nodes can ulcerate and discharge, mimicking septic arthritis.

This patient could have developed an acute inflammatory arthritis in addition to long-standing chronic gout which had been masked by long-term steroid use. This is an important differential diagnosis to make as the management of the two conditions is very different.

2. Aspirate from the knee helped confirm the diagnosis.

What are the likely findings?

Knee aspirate revealed negatively birefringent monosodium urate crystals. A diagnosis of gout is confirmed by the presence of uric acid crystals in a joint bursa or tophus.

Aspirate from his olecranon bursa was thick, chalky, and rich in urate crystals.

Ideally, affected joints should be aspirated. However, if there are no actively inflamed joints, aspirate and washout from unaffected joints can

aid diagnosis. The most common joint used in this situation is the knee. Diagnosis is confirmed if uric acid crystals are present in macrophages.

3. What is the significance of the rheumatoid factor and uric acid levels?

The rheumatoid factor is positive in approximately 10 % of patients over the age of 60, and the percentage increases with age. The ACCP antibody is more specific for RA, and can help to differentiate between the two conditions. However, negative ACCP antibodies do not help to differentiate between gout and rheumatoid arthritis.

Hyperuricaemia does not equate to a diagnosis of gout.

Furthermore, serum urate levels fall, and may be misleadingly low during attacks of gout. However, hyperuricaemia is the most important risk factor for developing acute gout, with a 5-year cumulative risk of one-third for patients with serum urate > 0.6 mmol/L.

4. What are the clinical manifestations of hyperuricaemia?

The clinical manifestations of hyperuricaemia are:

- ◆ asymptomatic hyperuricaemia
 - ◆ acute gout
 - ◆ recurrent gout
 - ◆ chronic tophaceous gout
 - ◆ renal stone
 - ◆ rarely urate nephropathy.
-

5. What management strategies will you suggest?

Gout is associated with hypertension, metabolic syndrome, insulin resistance diabetes, and chronic renal failure.

Once a diagnosis of gout is established, the aims of management are to control symptoms, prevent future attacks, and prevent structural damage of joints and kidneys.

This patient presents a number of management problems because of his long-term steroid use and comorbidities, including hypertension and borderline renal function.

NSAIDs should be stopped as they can exacerbate hypertension and decrease renal perfusion.

In addition, the combination with oral corticosteroids puts this patient at high risk of a gastrointestinal bleed. Cyclo-oxygenase-2 (COX-2) selective

NSAIDs such as etoricoxib and celecoxib have better gastrointestinal profiles, but should not be used in patients with pre-existing cardiovascular disease.

Oral colchicine at a dose of 500 µg twice to four times daily is an alternative treatment for inflammatory joint symptoms.

Higher doses can cause diarrhoea.

Simple analgesics should be used for pain relief.

Intra-articular or intramuscular steroids can help settle the acute inflammatory symptoms.

For long-term control of joint symptoms, the serum urate needs to be lowered and maintained below the saturation point for monosodium urate (<0.38 mmol/L).

Target levels for serum urate are <0.30 mmol/L (BSR) and <0.36 mmol/L (EULAR).

Patients with gout are either under-excretors or over-producers of uric acid.

This patient, as with 90 % of patients, is likely to be an under-excretor of uric acid.

Long-term treatment using uricostatic or uricosuric therapies is needed if patients are unable lower their serum urate sufficiently to prevent attacks of gout with lifestyle modification. This is especially so in renal failure patients with symptomatic gout.

The long-term treatment of choice is prevention of urate production using

allopurinol is a xanthine oxidase inhibitor which inhibits production of urate from hypoxanthine and xanthine.

Allopurinol should be started once the acute symptoms have

been settled for 2–6 weeks using colchicines (or NSAIDs if the patient is not in renal failure), otherwise there is a significant risk of acute gouty flare.

The starting dose depends on the GFR (> 80 mL/min, 300 mg daily; 15 mL/min, 50 mg on alternate days) This patient (GFR 60) should start at 100 mg daily and increase by 50 mg doses at fortnightly intervals until his serum urate is <0.030 mmol/L.

Transient rashes (2 %) are uncommon but usually settle with dose reduction. Rarely, a life-threatening allergic reaction with high fever, exfoliative dermatitis, acute hepatitis, interstitial nephritis, and vasculitis can occur. Desensitization regimes are possible, but are rarely used in practice.

Patients who are intolerant or allergic to allopurinol can use a uricosuric agent to enhance urate renal clearance. These drugs inhibit the urate anion exchange in the proximal nephron (URAT-1). Sulfipyrazone (200–800 mg/day in divided doses) is the only drug readily available in the UK, but requires normal renal function.

It is effective in diuretic-induced gout. Probenecid (0.5–2.0 g/day) can be used in mild renal failure (creatinine <200 mol/L) and is available on a named patient only basis in UK.

Benzbromarone (50–200 mg/day) is effective in mild renal failure (eGFR 30–60) but is unlicensed in the UK (available on named patient basis).

All three drugs have a significantly worse side-effect profile than allopurinol and are used as second-line agents in the UK. Benzbromarone can be used in combination with allopurinol.

Febuxostat (40–80 mg/day) is a recently developed non-purine selective xanthine oxidase inhibitor which is available to patients who are allergic to allopurinol and have failed uricosuric therapy.

Enzyme therapy with urate oxidase is now licensed for intravenous infusion

treatment for allopurinol-intolerant patients. As a new therapy, the use will be limited by antibody formation and cost.



Fig. 5.1 X-ray of patient's hands.

November 27, 2015

Case Study- Pediatric Rheumatology أجب بنفسك

An eight-year-old boy presents to your office for an urgent visit for a rash. They have primarily noticed a rash to the child's hands, knees, and elbows.

A very close look at the child's fingernail area finds the following (in photo):

أجب بنفسك

- 1- What is your provisional diagnosis??
- 2- What associated symptoms might be expected on review of systems?
 - a) fluctuation of the rash with twice daily fevers
 - b) blue color changes to the hands with cold exposure
 - c) oral ulcers
 - d) new difficulty keeping up with peers in soccer
- 3- What lab tests would be particularly helpful to you in pursuing a diagnosis?
 - a) CBC with diff/plts, ESR, ANA
 - b) amylase/lipase, CMP, ESR
 - c) CPK, AST, ALT, LDH, aldolase
 - d) UA with protein:creatinine ratio, double stranded DNA, ANA
- 4- What are clinical signs of potentially serious complications to be watched for in juvenile dermatomyositis, regardless of therapies?
 - a) change in voice noted by parents
 - b) child's avoidance of solid foods
 - c) bloody stools
 - d) respiratory distress
 - e) all of the above



Sherry Kamel Provisional diagnosis DM.... 2-D... 3_C...., 4_D
Aliaa Omar El-hady 1), 2), 3) correct but 4) is e

Soha Senara 1- Provisional diagnosis DM

2-b

3_C

4_e

Aliaa Omar El-hady 1), 3), 4) correct but 2) is D

Aliaa Omar El-hady 1) correct diagnosis: Juvenile Dermatomyositis

Aliaa Omar El-hady 2) Correct answer: D - New difficulty keeping up with peers in soccer.

The rash pictured is indicative of juvenile dermatomyositis (JDMS). The JDMS rash tends to involve extensor surfaces, including hands, elbows and knees as pictured. When flat these lesions are referred to as Gottron's sign, when raised they are referred to as Gottron's papules. While not specific for dermatomyositis, changes to the nailbed capillaries as seen in

the close-up picture are classically seen in JDMS. A purple hue to the eyelids is also part of classical JDMS skin changes, referred to as the 'heliotrope' rash. The rash of JDMS may bring the child to medical attention before the onset of significant weakness. It is therefore critical to probe for signs of even subtle weakness, such as trouble keeping up with peers in physical activities.

Fluctuation of rash with twice daily fevers would be suggestive of the Still's rash of systemic juvenile idiopathic arthritis. Blue color changes to the hands with cold exposure may indicate Raynaud's Phenomenon, which is more likely to be associated with lupus or scleroderma; Raynaud's is not classically associated with JDMS. Oral ulcers are non-specific, and are not indicative of JDMS.

Aliaa Omar El-hady 3) Correct answer: C - CPK, AST, ALT, LDH, aldolase

The rash and description of difficulty keeping up with peers in sports raises concerns of juvenile dermatomyositis (JDMS) or possible another muscle problems. It is helpful to get a panel of muscle enzymes rather than just a CPK, as the CPK may be normal even in the setting of active myositis. The panel of CPK, AST, ALT, LDH and aldolase will give more information regarding possible myositis than the CPK alone.

The other possible answers are not as helpful to screen for muscle disease. Answer A (CBC with diff/plts, ESR and ANA) may provide useful basic information, though all of these parameters could be normal in JDMS. Answer B (amylase/lipase, CMP, ESR) may be helpful in consideration of pancreatitis, though does not screen effectively for muscle disease. Answer C (UA with protein: creatinine ratio, ANA, double stranded DNA) would be more useful to screen for lupus than for muscle disease.

Aliaa Omar El-hady 4) Correct answer: E - all of the above Juvenile dermatomyositis requires constant monitoring of patients, even after immunosuppressive therapies are initiated. A change in voice noticed by family or friends can indicate pharyngeal muscle weakness and a choking risk. Pharyngeal

muscle weakness can also manifest as a change in the child's dietary choices, avoiding solid foods that become hard to swallow. Bloody stools may indicate that a child with JDMS has significant involvement of the GI tract, which poses a risk of perforation. Juvenile dermatomyositis can be associated with pulmonary involvement of the disease itself, which is rare, but a poor prognostic sign.

Case 9

Aliaa Omar El-hady

November 26, 2015

Case Study- Pediatric Rheumatology اجب بنفسك

A 10 year old girl is brought to your office with complaints of right knee pain. She and her mother are not sure when this started, but she thinks something has been wrong for a few weeks. Her knee symptoms are worse first thing in the morning, but by lunch time she is better. This does not seem to be keeping her from activities, but mom thinks she limps when she runs. She has not been ill recently, has had no fevers, no rashes or any other symptoms. There is no known history of trauma. Past medical history is unremarkable. Family history finds no rheumatoid arthritis or other autoimmune diseases.

1) This child's knee pain falls best into which major category of pain?

- a) inflammatory
- b) mechanical
- c) bony
- d) neuropathic

اجب بنفسك

2) Which of the following pairs of exam findings would be most consistent with this category of pain?

- a) erythema overlying the knee, difficulty weight bearing
- b) hyperextension, significant pain with walking
- c) loss of visual landmarks, increased warmth to the knee
- d) pain to palpation at the tibial tuberosity, intoeing with gait

اجب بنفسك

3) You do a thorough joint exam and find all joints other than her right knee to be normal. What would a differential diagnosis for this child include?

اجب بنفسك

4) On further questioning mom tells you that her daughter has been waking up at night in pain. How does this change the differential diagnosis for this child?

اجب بنفسك

5) What labs would be most helpful in the initial workup of this child?

- a) ANA, ESR, CRP
- b) ANA, Rheumatoid factor, ESR
- c) CBC with diff/plts, ANA, Rheumatoid factor
- d) CBC with diff/plts, ESR, CRP



Amg Amg 1a

2c

3 DD:JIA

SLE

4 no change in my DD

5 b

Aliaa Omar El-hady Correct answer: اجابة السؤال الاول Correct

A-inflammatory

This child is described as having her worst symptoms in the morning, improving over the course of the day. This is the typical symptom pattern of inflammatory joint pain.

Mechanical pain typically is best a rest, and worsens with activities.

Bony pain is characterized by nighttime awakening, and does not tend to vary over the course of the day or with activity as seen with inflammatory and mechanical causes of pain.

Case 10

Aliaa Omar El-hady

November 27, 2015

Case Study- Pediatric Rheumatology **اجب بنفسك**

A 10-year-old violinist comes in with complaints of joint pain for the past month. She has state-wide competition coming up next week, so has been practicing more than usual for the past

several weeks. She placed second in the state last year in her age group, and is extremely focused on winning this year. She particularly complains of wrist and elbow pain after long practice sessions. She does not generally have pain in the morning. She is well appearing, and her general exam is normal. Joint exam does not find any swelling, though her elbows and wrists are tender to palpation. Both wrists extend past 90 degrees; both elbows extend past 180 degrees.

أجب بنفسك عن الاسئلة التالية

1. This patient's elbow pain falls best into which major category of pain?
 - a) Inflammatory
 - b) Mechanical
 - c) Bony
 - d) Neuropathic
2. Which of the following additional factors would be most consistent with this category of pain?
 - a) The pain awakens her at night
 - b) Wearing a flexible brace helps the pain
 - c) The family has frequently seen erythema overlying the elbow
 - d) Ice worsens the pain
3. What would be the most helpful interventions to suggest to this driven young musician?
 - a) Suggest she choose to play a different instrument
 - b) Ice/rest between practice sessions, physical therapy
 - c) Recommend a short burst of corticosteroid with a Medrol dose pack
 - d) Recommend Lortab (acetaminophen/hydrocodone) to be used only for extreme pain until the competition is over.



Photo 1



Photo 2



Photo 3

Sherry Kamel 1_B..., 2_B.. 3_D

Sara Saeed Mechanical

Sherry Kamel The cause is hypermobility so the pain is mostly from mechanical stress

Aliaa Omar El-hady excellent

Sara Saeed All b

Aliaa Omar El-hady 1),2) correct & 3) incorrect

Amg Amg 1b

2b

3d

Aliaa Omar El-hady excellent

Mai Rabie 1/2/3-----b

Aliaa Omar El-hady 1),2) correct & 3) incorrect

Gigi Elzohirey 1/b

2/b

3/b

Aliaa Omar El-hady 1),2) correct & 3) incorrect

Aliaa Omar El-hady 1) Correct B - Mechanical

This patient has had the onset of elbow pain in the setting of significantly increased activity over the past month. Her pain worsens the more that she does. This pattern is most consistent with mechanical pain. In addition, she has no exam findings of joint inflammation, with no swelling or decreased range of motion. Rather than decreased range of motion, her exam finds hyperextension of her joints.

Inflammatory pain tends to improve with increased activity.

Bony pain does not tend to correlate directly with the level of activity, nor does neuropathic pain.

Aliaa Omar El-hady 2) Correct B - wearing a flexible brace helps the pain

Mechanical pain tends to improve with rest. A flexible brace would help this patient by supplying support and some degree of stabilization of her lax joints.

Mechanical pain does not typically awaken children from sleep, this is more indicative of bony pain.

Erythema overlying the joint is not typically seen in mechanical pain. This is most often seen in septic joints, even more so than arthritic joints.

Ice tends to help mechanical pain. Worsening with ice can be seen in inflammatory joints, as this tends to cause increased joint stiffness.

Aliaa Omar El-hady 3) Correct D- Recommend Lortab (acetaminophen/hydrocodone) to be used only for extreme pain until the competition is over.

..

Case 11

A 52 year old woman with a long history of photosensitivity and facial skin rashes treated by a dermatologist presented with

proteinuria and facial skin lesions in a butterfly distribution as shown in the picture. The differential diagnosis consists of:

1. Acute butterfly skin rash of lupus erythematosus
2. Atrophic skin changes due to local corticosteroid treatment
3. Chronic lupus erythematosus with a butterfly appearance
4. Combination of skin lesion due to chronic lupus erythematosus and local treatment with corticosteroids.



Aliaa Omar El-hady

Final answer :

Combination of skin lesion due to chronic lupus erythematosus and local treatment with corticosteroids.

Rheumatology Case 4



A 52 year old woman with a long history of photosensitivity and facial skin rashes treated by a dermatologist presented with proteinuria and facial skin lesions in a butterfly distribution as shown in the picture. The differential diagnosis consists of:

1. Acute butterfly skin rash of lupus erythematosus
2. Atrophic skin changes due to local corticosteroid treatment
3. Chronic lupus erythematosus with a butterfly appearance
4. Combination of skin lesion due to chronic lupus erythematosus and local

treatment with corticosteroids.

THIS IS THE RIGHT ANSWER

Skin lesion due to a combination of chronic lupus erythematosus and local treatment with corticosteroids. This picture shows large atrophic skin plaques in a butterfly distribution with discoloration and hypopigmentation. These findings are seen in chronic lupus erythematosus but local steroid treatment may have contributed to the picture.

Case 12

Aliaa Omar El-hady

November 27, 2015

A 55 year old woman with a history of “bronchial asthma”, recurrent iritis and articular chondritis presented with a high fever. Clinical examination revealed a dyspnoeic patient with a moon face and a saddle-shaped nose with diffuse wheezing bilaterally over the lungs. Laboratory evaluation showed leukocytosis with polymorphonuclearcytosis, high ESR, high CRP, and negative ANCA. The chest X-ray was normal. The differential diagnosis consists of:

1. Relapsing polychondritis
2. Cogan's syndrome
3. Wegener's granulomatosis
4. Systemic vasculitis (Churg-Strauss syndrome)



Aliaa Omar El-hady Final answer: Relapsing polychondritis

Rheumatology Case 3



A 55 year old woman with a history of "bronchial asthma", recurrent iritis and articular chondritis presented with a high fever. Clinical examination revealed a dyspnoeic patient with a moon face and a saddle-shaped nose with diffuse wheezing bilaterally over the lungs. Laboratory evaluation showed leukocytosis with polymorphonuclearcytosis, high ESR, high CRP, and negative ANCA. The chest X-ray was normal. The differential diagnosis consists of:

1. Relapsing polychondritis
2. Cogan's syndrome
3. Wegener's granulomatosis
4. Systemic vasculitis (Churg-Strauss syndrome)

THIS IS THE RIGHT ANSWER

This patient suffered from recurrent asthma attacks over the years due to cartilaginous inflammation of the main airways. Further clinical manifestations of relapsing polychondritis include auricular chondritis, iritis and nasal chondritis which results in a saddle-shaped nose.

Case 13

Sherry Kamel

November 29, 2015

Case

A 55-year-old man returns to the clinic for follow-up of osteoarthritis of his knees. The patient reports that his pain is 4/10 in intensity. Acetaminophen is effective for the pain. He reports performing quadriceps strengthening exercises and running for 2 miles 3 times weekly.

On examination, his knees have no warmth, effusions or instability, but there is a mild valgus deformity bilaterally. The range of motion is normal with mild crepitus. The patient also has squaring of the first carpometacarpal joints, Heberden's and Bouchard's nodes, bilateral reduced internal rotation at the hips, and hallux valgus deformities.

His laboratory results include a vitamin D level of 10 ng/mL.

Question

Which of the following is most likely to predict progression of osteoarthritis of the knee?

- A. Low vitamin D level
- B. Lower body mass index
- C. Osteoarthritis in multiple joints
- D. Regular running for exercise
- E. Younger age

Sherry Kamel correct answer is C.....

Identification of patients who are at risk of progression of osteoarthritis is desirable to direct patients to appropriate interventions.

Patient characteristics with the strongest evidence to predict progression of knee arthritis are advanced age, multiple joint involvement, greater body mass index, worse radiographic findings, and varus malalignment.

There is conflicting evidence regarding low vitamin D levels and structural changes in knee osteoarthritis and its symptoms. In a prospective study by McAlindon and colleagues supplementation of vitamin D for 2 years failed to reduce pain or improve cartilage loss in patients with symptomatic knee osteoarthritis.

Participation in sports such as running is not associated with

worsening of osteoarthritis of the knee. Patients may be reassured that moderate participation in these activities may be continued. In fact, avoidance of activity may lead to increased joint instability and more disabilities

Case 14

Aliaa Omar El-hady

November 29, 2015

Nice case from Dr. **Rageh M. Elsayed** منقول من جروب اخر

Male pt. 58 ys diagnosed as seropositive RA for 5 years under control with MTX 12.5 mg weekly and HCQ 200mg /day came to me today with acute developing within 5 days nodulosis LT.elbow and bilateral dorsal forearm Very small one in LT index movable not painful I aspirated LT olercrnon rheumatoid nodule 2 years ago with local injection and totally improved.
Now No activity of RA no morning stiffness no tender or swollen joints . chest free clinically and with normal x Ray plus normal lab I diagnose the case as MTX acute induced nodulosis (MAIN) I decrease dose of MTX to 10mg add colchicine twice plus HCQ and CA and vit D for your diagnosis and management



Aliaa Omar El-hady



Tamer Elfarahaty Yes; 👍 u are right : MTX induced nodulosis as your patient in remission (not RA nodules). If not decreased with low dose MTX; stop it and add other DMARDs like immuran or salzopyrin plus colchicine & HCQ.

Like · Reply · 👍 5 · October 24 at 9:21pm · Edited



Rageh M. Elsayed Yes thanks dr Tamer Elfarahaty I decreased MTX And will see after one month if no improvement I will stop it and add other DMARDs but I don't prefer immuran as it can cause nodulosis also and salazopyrin not available in KSA I prefer leuflonamide in such case

Like · Reply · 👍 2 · October 24 at 9:39pm · Edited



Tamer Elfarahaty 👍👍

Like · Reply · 👍 1 · October 24 at 9:39pm

Aliaa Omar El-hady

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International Journal of Rheumatic Diseases

Leflunomide-induced nodulosis in a case of Rheumatoid arthritis

P. S. ARUL RAJAMURUGAN, C. PANCHAPAKESA RAJENDRAN, S. RUKMANGATHARAJAN, S. RAJESWARI and R. RAVICHANDRAN

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leflunomide; nodulosis

Abstract

We herein report accelerated nodulosis in a 49-year-old woman with rheumatoid arthritis who was treated with methotrexate and leflunomide. She developed multiple pulmonary and subcutaneous nodules 2 years after the addition of leflunomide to methotrexate. The nodules developed when the rheumatoid arthritis was in remission. The pulmonary nodules regressed following the institution of hydroxychloroquine after stopping leflunomide.

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Aliaa Omar El-hady

Like · Reply ·  2 · October 24 at 9:54pm




Rageh M. Elsayed Thanks a lot dear friend Tamer this is new for me now we are stucked

Like · Reply ·  2 · October 24 at 9:59pm



Rageh M. Elsayed Dear dr Howaida Elsayed Mansour Amal Elganzory Omer Mala Ahmed Fatemah Elshabacy Mona Mansour Mohammed Hassan Hany El-saadany etc.....

Like · Reply ·  1 · October 24 at 10:03pm



Hany El-saadany I'm totally agree with you Dr Rageh M. Elsayed

Like · Reply ·  1 · October 24 at 10:37pm




Mohammed Hassan good evening dear dr sayed perfect management totally agree

Like · Reply ·  1 · October 24 at 11:40pm



Howaida Elsayed Mansour Dear all, thanks dr.Rageh M.Elsayed actually yes MTX can do this but I need to ask did this pateint has Rheumatoid nodules before MTX? What about his CRP, ESR ?? Does he has any pulmonary infiltrate or nodules ??

Like · Reply ·  1 · October 25 at 12:04am



Rageh M. Elsayed Yes dr Howaida Elsayed Mansour 2 years ago pt got LT olecronon rheumatoid nodule I inject it and it is totally improved chest free clinically and no x Ray findings his lab is free esr 15 and crp - ve all this nodulosis only in 1 weak

Aliaa Omar El-hady



Rageh M. Elsayed Dr Basant Esawy opinion

Like · Reply · October 24 at 10:52pm



Omer Mala Ahmed Thanks Dear Dr Rageh M. Elsayed for sharing this rare & nice case .

I am totally agree with you it's a case of methotrexate-induced accelerated rheumatoid nodulosis (MIARN) as the patient is clinically in remission & got accelerated Nodulosis.

○ Patients with MIARN report increased numbers of nodules, often painful and localized to the hands,

○ To me because the patient got great benefit from MTX & he got remission with this golden drug I prefer to not stop or change the MTX to another DMARDs because of Nodulosis, as The clinical symptoms from nodulosis are mild (mildly painful) and tolerable in the majority of patients, and most other effective DMARDs & Even Some Biological agents can induce Nodulosis in such genetically predisposed cases for Nodulosis, thus I prefer the MTX to be continued for the management of this case,

○ I agree with you to decrease the MTX dose to the level that can maintain the remission with adding hydroxychloroquine, penicillamine, colchicine, and sulfasalazine to MTX therapy may decrease nodule frequency.

○ Accelerated rheumatoid nodulosis, although classically associated with methotrexate, may also develop as a consequence of etanercept, infliximab, or azathioprine therapy.

Like · Reply · 4 · October 25 at 12:11am · Edited

Aliaa Omar El-hady



Fatemah Elshabacy Thanks for this nice case I agree with you this is a case of main. The best is to reduce the dose of MTX, add HCQ, colchicine and low dose steroid as you did I prefer not to stop MTX as some reports documented that it's a self-limiting condition even with continuation of MTX you can also switch to leflunomide even if it's reported to cause nodulosis too. Finally you should monitor this patient frequently as it's reported that cases with nodulosis may be associated with secondary vasculitis

Like · Reply · 7 · October 24 at 11:58pm



Basant Esawy Thank you Dr Rageh M. Elsayed for sharing interesting case

Totally agree with your line of management

Follow up your case closely and if started to have rising phase reactant or increasing Doppler signals you should optimize your medication either to add or shift to leflunomide or SSZ it is available in ministry of health, national guard or military hospitals

Like · Reply · 4 · October 25 at 6:45am

Case 15

Case2

A 56-year-old man presents with difficulty moving both hands for 6 months.

He denies pain or swelling in any of his joints, and has no numbness or tingling in his hands. His hands do feel weak. He has a long history of hypertension, hyperlipidemia, and type 2 diabetes mellitus.

disease.

His physical examination is notable for difficulty flattening his hands against the surface of a table. No joint tenderness, redness, warmth, or swelling are noted. No thickening or nodulosis of the palmar fascia is palpable. His most recent hemoglobin A1C level is 8.2% (reference range: 4.0–6.1%).

Which of the following is the most likely cause of his problem?

- A. primary OA of hand joint.
- B. Complex regional pain syndrome
- C. Diabetic cheiroarthropathy
- D. Flexor tenosynovitis

Sherry Kamel Correct Answer is C. Diabetic cheiroarthropathy

Sherry Kamel Diabetic cheiroarthropathy (answer C) is typically seen in patients with longstanding and poorly controlled disease, though it can be seen early in the disease course. The incidence is not entirely clear, though it does appear to be dropping, likely due to better glycemic control on a population level. It is due to deposition of abnormal collagen around the joints, leading to limited mobility and stiffness. It is typically painless, though it can cause loss of grip strength and loss of hand function. Classic findings include the “prayer sign” (inability to flatten hands when pressed against each other) and the “table top test” (Inability to flatten hands against the surface of the table). **Sherry Kamel** # Flexor tenosynovitis can be seen in up to 5% of patients with DM. Patients will typically present with a trigger finger, and the examination may reveal a palpable nodule and thickening of the flexor tendon. None of this was seen in this patient.

Sherry Kamel # Complex regional pain syndrome (previously called reflex sympathetic dystrophy) presents with severe pain and usually a burning sensation, often accompanied by changes in the skin and hair in the area and changes in temperature in the affected limb. It is thought to be more common in patients with DM, but the incidence is not clear. As this patient does not have pain, this answer is not correct.

Case 16

Aliaa Omar El-hady

November 26, 2015

Case study with its solution حالة امتحان commentary

Lupus with Pregnancy حالة تعليمية

ازاي تفكر فى الحالة للوصول للتشخيص السليم

A 30-year-old female with a 10-year history of systemic lupus erythematosus (SLE) was reviewed in clinic. She had recently married and was keen to start a family.

At diagnosis she had presented with a photosensitive rash, fleeting arthralgia, migraine, depression, and proteinuria.

A renal biopsy had confirmed membranous glomerulonephritis, consistent with class V lupus nephritis.

She was initially treated with prednisolone and azathioprine, but ongoing active renal disease necessitated escalation to cyclophosphamide and subsequent maintenance therapy with mycophenolate mofetil 1g twice daily.

Examination was normal, including a blood pressure of 120/80 mmHg. Dipstick urinalysis was normal.

اجيبوا على هذه الاسئلة Questions

1. How would you assess her disease activity? What other tests would you consider in preparation for pregnancy?
2. What pre-conception counselling would you provide with regard to the following?
 - i. Medication and contraception.
 - ii. Renal disease.
 - iii. Pregnancy-related risks? What additional monitoring may be required during -pregnancy?

Answers:

1. How would you assess her disease activity? What other tests would you consider in preparation for pregnancy?

Pregnancy outcome is better if conception occurs during a period of remission, or 6 months after control of a flare or a change in maintenance therapy.

Disease activity in SLE can be assessed using the SLE Disease Activity Index, a global disease activity score (DAS) validated against experienced clinical judgement used to quantify organ involvement and guide therapeutic management.

Pre-conception all patients with SLE should be screened for a lupus anticoagulant, antiphospholipid, and anti-Ro and anti-La antibodies.

Anticoagulants including aspirin and heparin have been shown to improve pregnancy outcome in women with antiphospholipid syndrome (APS) .

Ds DNA, anti-Ro antibodies, and anti-La antibodies may result in neonatal lupus which requires further monitoring

2. What pre-conception counselling would you provide with regard to the following?

- i. Medication and contraception.
- ii. Renal disease.
- iii. Pregnancy-related risks.

What additional monitoring may be required during pregnancy?

i. Patients taking teratogenic medications should be advised regarding contraception, avoiding oestrogen-containing preparations due to the risk of flare. Animal studies suggest that mycophenolate mofetil is associated with an increase in congenital malformations and should be avoided in pregnancy.

It is standard practice to switch to azathioprine and hydroxychloroquine, as was done in this case, which are considered safe in pregnancy.

ii. There is a risk of deterioration in renal function due to the change in medication or as a result of pregnancy. The risk is higher with pre-existing hypertension, proteinuria (> 1 g/24 h), or high baseline serum creatinine (> 125 μ mol/L).

iii. Lupus itself does not usually affect fertility, but NSAIDs, previous cyclophosphamide treatment, and ongoing disease activity may prevent conception. There are increased risks of early miscarriage, intra-uterine fetal death, pre-eclampsia, intra-uterine growth retardation, and pre-term delivery.

Pregnancy may increase the risk of flare both antenatally and in the puerperium.

Patients with active lupus, particularly if nephrotic, are at increased risk of venous thromboembolism (VTE) in pregnancy. Therefore it is imperative that a detailed history is taken of previous history of clots or other risk factors, and thromboprophylaxis should be considered.

Women with APS are at increased risk of VTE and fetal loss, and low-dose aspirin and low molecular weight heparin are recommended throughout pregnancy and 6 weeks post-natally. Such patients should be managed under collaborative care of obstetrics and haematology.

Increased maternal and fetal surveillance is required during pregnancy, particularly in women with hypertension, renal disease, APS, and Ro antibodies. Ro antibodies are associated with congenital heart block in 1–2 % of cases; early cardiac fetal monitoring is important in detecting this as it can result in intra-uterine death. Ro and La antibodies can cross the placenta and 5 % of babies may suffer a neonatal lupus syndrome which is transient.

استكمال للحالة

She conceived 8 months later and was initially well, but at 21 weeks' gestation was noted to have deteriorating renal function and hypertension (BP 170/110 mmHg).

Investigations showed:

- ◆ urea 18 mmol/L
- ◆ creatinine 171 μ mol/L
- ◆ albumin 16 g/dL
- ◆ urinary protein 10 g/24 h.

Questions

3. There are two main causes of this presentation, what further investigations would you request in order to differentiate between the two?

Answer

Deteriorating renal function, hypertension, and proteinuria suggest a flare of her lupus nephritis, pre-eclampsia, or both. These conditions are potentially lifethreatening to both mother and baby. The features distinguishing a lupus flare and pre-eclampsia are shown in Table.

Steroids are first-line therapy for lupus flare during pregnancy. Prednisolone is inactivated by placental 11 β -hydroxysteroid dehydrogenase 2 so that only 10 % of the active drug reaches the fetus. High-dose steroids increase the risk of maternal gestational diabetes, hypertension, infection, and osteoporosis. Other immunosuppressive agents that are considered to be safe in pregnancy include azathioprine, hydroxychloroquine, cyclosporin, tacrolimus, and intravenous immunoglobulin. There are few data for the use of biological agents such as anti-TNF therapy, but so far there is no suggestion of adverse maternal or fetal outcome. In rare severe cases, cyclophosphamide has been used in pregnancy.

Table 9.1 Features distinguishing a lupus flare from pre-eclampsia


	Lupus flare	Pre-eclampsia
Hypertension	Yes	Yes
Urine analysis	Proteinuria	Red cell casts and proteinuria
Platelet count	Low	Low
Abnormal LFTs	Unusual	Common
Creatinine	Raised	Raised
Serology	Raised dsDNA and low C3/C4	Normal
Uric acid	Normal	High

Amg Amg


رائعة
اللهم اشف مرضانا ومرضى المسلمين أجمعين

Safaa Sayed Also red cell cast is present in lupus nephritis characteristic????or pre eclampsia only dr Aliaa

Aliaa Omar El-hady



	<i>PEC</i>	<i>SLE</i>
◆ C3-C4-C50	May be low	Almost always low
◆ RBC Cast	Rare	Frequent
◆ Aminotransferases	May be increased	Rarely abnormal
◆ Onset of proteinuria	Abrupt	Gradual/Abrupt
◆ 24hr proteinuria	2-25g	2-25g
◆ Thrombocytopenia	Will not differentiate	
◆ Hyperuricemia	Will not differentiate	
◆ Hypertension	Will not differentiate	



Case 17

Case Report (Scleroderma renal crisis)

A 60-year-old male presented through the outpatient department (OPD) with complaints of shortness of breath on exertion and vomiting for the preceding two months.

The patient was found to be hypertensive one year earlier with irregular follow-up. He had been recently admitted to another hospital about six months earlier with chronic constipation, abdominal pain, multiple joint pains and itching.

The presence of characteristic clinical features led to the diagnosis of scleroderma. His serum creatinine gradually increased from 2.2mg/dl at presentation to 3.0 mg/dl at the time of discharge.

On presentation at our hospital, the patient still had joint pains with morning stiffness, fatigue and inability to stand up from sitting position and generalised itching for the preceding months.

On examination, blood pressure was found to be 150/100 mmHg, with generalised xerosis of the skin, hyperpigmented areas interspersed with hypopigmented areas, pallor, clubbing, microstomia and onycholysis.

Chest examination revealed decreased breath sounds at the bases. Joint examination showed restriction of movement in multiple small and large joints without effusion. Rest of the examination was unremarkable.

Initial investigations showed the following:

haemoglobin (Hb) levels to be 6.92g/dL;
white blood count (WBC) 8.44×10^3 /dL with normal differential;
serum creatinine 8.7mg/dL;
blood urea 273mg/dL;
serum bicarbonate HCO_3^- 22.4meq/L;
serum ionised calcium 1.23mmol/L;
serum sodium 131mmol/L; and
serum potassium 3.8meq/L.

Urine examination showed presence of proteins and no active sediment.

Urine protein to creatinine ratio was 2.1. Anti-Scl-70 was positive.

Serum intact parathormone level was 99.6pg/mL.

Ultrasonographic scan of the abdomen revealed normal-sized kidneys with grade two renal parenchymal changes and small pleural effusions bilaterally.

There was no post-micturition residual volume.

Echocardiogram (ECG) was suggestive of hypertensive and ischaemic heart disease.

Three units of packed red blood cells (RBCs) were transfused to stabilise the haemoglobin levels.

A renal biopsy was carried out that revealed 29 glomeruli - arterial wall showed marked thickening by concentric fibrosis and narrowing of the lumen (Figure 1-A); sclerosis and fibrous crescent formation was seen in 9 out of 29 glomeruli; atrophic tubules and interstitial fibrosis were also noted (Figure-1-B).
(photo)

A diagnosis of scleroderma renal crisis was made. Treatment with short-acting ACE inhibitor was initiated at low dose (Table).

Follow-up visit after one week showed a downward trend of serum creatinine. Two weeks later, the patient was re-admitted with complaints of diarrhoea and vomiting. He had undergone tooth extraction and received non-steroidal anti-inflammatory drugs (NSAID) and antibiotics four days earlier.

On presentation, he was dehydrated, and serum creatinine had again increased to 7.3mg/dL while serum electrolytes were normal. He was rehydrated and antibiotics were initiated.

On the second day of admission, he was found to be confused and later comatose.

Evaluation suggested brainstem stroke and 24 hours later he developed cardiopulmonary arrest and died.

Discussion

Renal involvement is common in systemic sclerosis. Our patient had all the characteristic features and serology supportive of systemic sclerosis and severe degree of renal crisis that responded to ACE inhibitor treatment.

SRC, a severe and life-threatening renal disease, develops in approximately 10% to 15% of patients with the diffuse cutaneous form of systemic sclerosis, and arises much less frequently in limited cutaneous systemic sclerosis.

SRC is an early complication of systemic sclerosis that almost invariably occurs within the first year of onset of the disease. In a series of 110 patients, renal crisis occurred at a median duration of 7.5 months from the onset of the disease.² Our patient had features suggestive of scleroderma for less than a year.

Risk factors for development of renal crises include the use of glucocorticoids, diffuse skin involvement, and presence of auto-antibodies directed against ribonucleic acid (RNA) polymerase. Our patient did not receive steroids; however he did have diffuse skin involvement.

SRC is characterised by the following findings: acute kidney injury, abrupt onset of moderate to marked hypertension, and a urine sediment that is usually normal or reveals only mild proteinuria with few cells or casts. Our patient had non-nephrotic proteinuria and no active sediment.

The characteristic histological finding is the presence of intimal proliferation and thickening that leads to narrowing and obliteration of the vascular lumen, with concentric "onion-skin" hypertrophy, as was also evident in our patient.

Blood pressure control is the mainstay of therapy in SRC.

Aggressive treatment of hypertension can stabilise or even improve renal function in up to 55-70% of the cases, if started before irreversible vascular injury has occurred.

An ACE inhibitor is the agent of choice, leading to an improvement in blood pressure in up to 90% of patients by reversing the angiotensin II-induced vasoconstriction.¹⁰ Nevertheless, the mortality is high and a poor outcome is common.

Despite treatment with ACE inhibitors, approximately 20% to 50% of patients with SRC progress to end-stage renal disease. However, among patients with SRC who require dialysis during an acute episode, an appreciable proportion recover sufficient renal function to discontinue dialysis.

Our patient had a very low glomerular filtration rate (GFR) and we opted to treat the SRC without dialysis due to the fact that financial burden for maintenance haemodialysis was of great concern in our patient. He did have improvement in the GFR, thus avoiding dialysis, but the condition deteriorated due to the use of NSAID and dehydration secondary to diarrhoea.

Conclusion

Scleroderma renal crisis, if diagnosed, deserves a trial of ACE

inhibitors even at an advanced stage, with the likelihood of improvement of the kidney function.

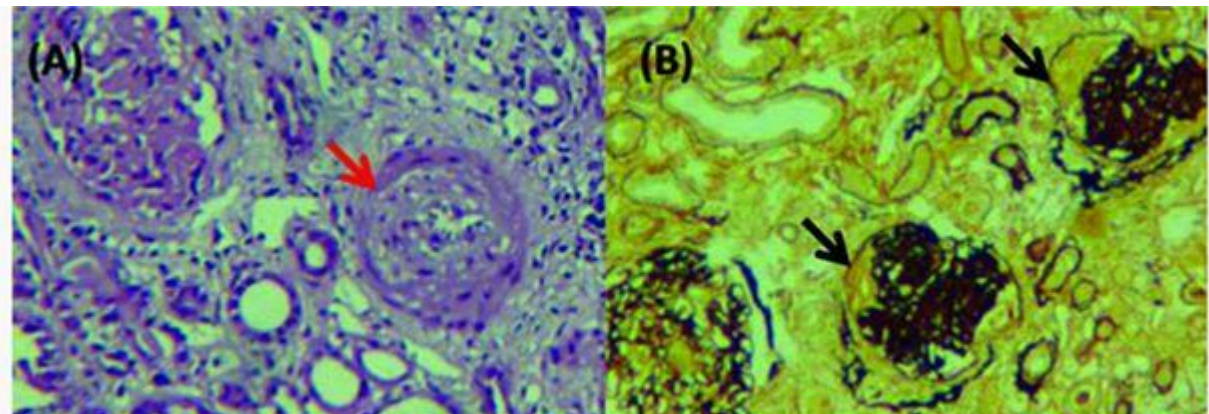


Figure: A) Hematoxylin and eosin (H&E) stain shows concentric hypertrophy (onion skin appearance) of blood vessel (red arrow). A sclerosed glomerulus is also seen with severe interstitial fibrosis. B) Silver methenamine stain showing two glomeruli with fibrous crescents (black arrow), and one with early segmental change.

Table:

Date	Serum Creatinine (mg/dL)	Blood Pressure (mmHg)	Anti-hypertensive Medications Used
27/11/10	8.7	180/100	Nifedipine Retard 20 mg BD. Methyldopa 250 BD.
4/12/10	8.1	150/80	Captopril 6.25 mg BD
7/12/10	8.0	140/80	Captopril 12.5 mg BD
9/12/10	8.2	140/80	Captopril 12.5 mg QID
16/12/10	7.8	140/80	Captopril 12.5 mg TDS
21/12/10	7.3	120/80	Captopril 25 mg TDS
28/12/10*	5.9	120/80	Captopril 25 mg TDS

*Follow-up visit one week later.

Case 18

Omer Mala Ahmed

November 28, 2015 · Ranya, Iraq

♻️ 13 years old boy presented to me today at 5:00 pm complaining of bilateral knees & ankle pain & limping, pain & limping were maximum in the morning, the condition started 4 weeks ago as left knee pain & limping, 1 week later involved right knee & in the last 5 days involved both ankles in additive pattern.

▪ The condition preceded by sore throat & cough by 5 days.

▪ The condition associated with fever & rigor

□ O/E : at 5:00pm

The child still has limping gait,

The joints are very tender on palpitation, painful limitation of left knee & left ankle joints, minimal swelling, no overlying skin changes.

No skin rashes

No lymphadenopathy & no organomegaly.

No skin lesions

Temperature : 38°C

Eye Examination: Normal

□ INVESTIGATIONS:

▪ CBC : Unremarkable

▪ ESR : 97

▪ CRP : 1/640

■ASO: 1/600

■Latex : -ve

■Brucella : -ve

■GUE : Normal

■CXR , ECHO & ECG pending(tomorrow) .

□DIAGNOSIS:

Post streptococcal Reactive Arthritis (PSRA)

□Treatmen:

Amoxiclav (500/125) for 10 days

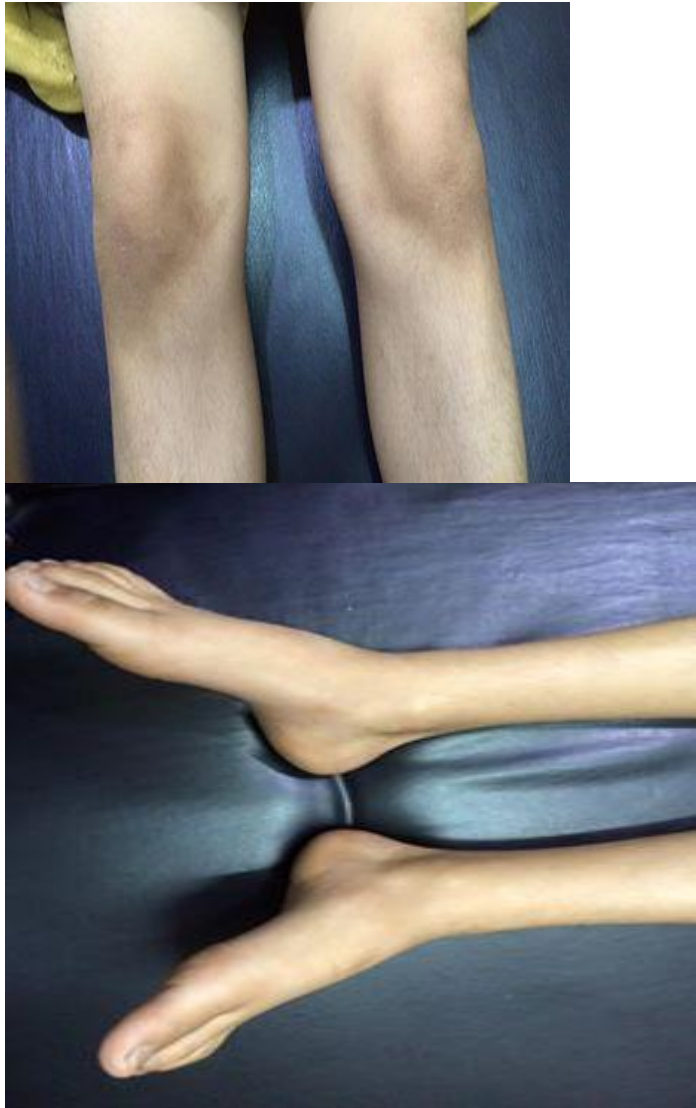
ASA 1800 mg in 4 divided doses with gradual tapering.



Your advices regarding the diagnosis & treatment of this case ?

Why it's not JIA or ARF ?





Wajeeh Mahmood the rapid response to ASA may help in the confirmation of diagnosis.

Howaida Elsayed Mansour Thanks dear dr. **Omer Mala Ahmed** for your interesting cases, to me this boy is likely systemic onset JIA (juvenile still's disease) why? bec.of the additive pattern of arthritis the very high CRP the sorethroat the presence of fevere specially with rigors as rigors are very chch of systemic onset JIA ...please check for s.ferritin, ANA, urine proteins and RF , he should be ttt by 15 mg oral steroids daily + 80 units MTX weekly + ca and vit D

Aliaa Omar El-hady



Hany El-saadany Thank you Dr.Omer , First I'd like to know if he has a positive RF or not ,positive ANA or not if you please

Like · Reply · 1 · 8 hrs · Edited



Tamer Elfarahaty Additive pattern of arthritis is characteristic of JIA but duration less than, 6 week ;No rash (specific for still's) ;No hepatosplenomegally against still's diagnosis . What about pattern of fever, anticcp (RF negative) &anti ANA . Any eye complain (slit lamp) ; back pain or enthesopathy .

Like · Reply · 1 · 7 hrs



Rageh M. Elsayed Thanks dr Omer Mala Ahmed I am with you but work up to exclude JIA must be done

Like · Reply · 2 · 7 hrs



Tamer Elfarahaty additive (But not migratory???) arthritis with fever and increased ESR; CRP &ASO (repeat it 2 weeks later) fulfill the revised Jones criteria . wait ECG& ECHO (carditis) and see aspirin response to confirm Diagnosis of PSRA and rule out RF (still DD). Naproxyn 10 mg per kg bid has effect like aspirin

Like · Reply · 1 · 7 hrs



Tamer Elfarahaty additive (But not migratory???) arthrititis with fever and increased ESR; CRP & ASO (repeat it 2 weeks later) fulfill the revised Jones criteria . wait ECG & ECHO (carditis) and see aspirin response to confirm Diagnosis of PSRA and rule out RF (still DD). Naproxen 10 mg per kg bid has effect like aspirin

Like · Reply · 1 · 7 hrs



Omer Mala Ahmed Dear prof Tamer Elfarahaty what made me to diagnose the case as PSRA is the severe tenderness of the involved joints which is usually seen in reactive conditions (JIA usually has swelling with minimal pain) , very high titer of ASO , loss of migratory pattern not typical of ARF , on presentation to me he was feverish (38.6) but they said that the child has every night fever & rigor !! Even today he said i have cough & sore throat ! Which may be behind his continuous fever & rigor , tomorrow i will arrange CXR to exclude any associated pneumonia

Like · Reply · 2 · 7 hrs · Edited



Tamer Elfarahaty Yes I agree with u. I said additive pattern against RF but absence of carditis help more to confirm PSRA. And also not JIA (including still's) but work up to rule it must be done

Like · Reply · 1 · 7 hrs



Omer Mala Ahmed Great thanks for your informative comments , sorry i not remembered to tell you that the child free of back pain , enthesopathy & uveitis , tomorrow i will update you regarding the pending investigations

Like · Reply · 1 · 7 hrs

Aliaa Omar El-hady



Mohamed Magdy Thank you Dr : Omer Mala Ahmed for nice case , but I have some notes about your diagnosis :

- ☆ No PSRA in juvenile pt , because PSRA present in adult .
- ☆ what about serum ferritin ???
- ☆ what about the examination of both hips joints ???
- ☆ what about liver enzymes ???
- ☆ why do not you started by NSAID ???
- ✗ please repeat CBC again .
- ☆

Like · Reply · 1 · 5 hrs



Howaida Elsayed Mansour Thanks dr Omer Mala Ahmed for the interesting case, to me this is a systemic onset JIA (juvenile still's disease) why? because of: 1- the additive pattern of arthritis, 2- the very high ESR and CRP (much beyond the levels seen in ReA) , 3- the presence of persistent fever and most importantly the presence of rigors as rigors is very chch of still's disease fever in addition to sorethroat all point to SJIA...pls check for s.ferritin, ANA, RF and protein/C ratio best ttt is by steroids 15 mg daily + MTX 80 units weekly and hydroquinone 200 1x2

Like · Reply · 3 · 5 hrs · Edited



Mohamed Magdy But prof **Howaida Elsayed Mansour** , if the case is still's disease , the corner stone of ttt is steroid , and the dose 15 mg is not enough , 0

Like · Reply · 1 · 5 hrs



Howaida Elsayed Mansour Dr.Tamer Elfarahaty it is not essential at all- to see the transient very faint rash of stills disease and 6 weeks is needed for the classification not the diagnostic criteria of SJIA...

Like · Reply · 2 · 5 hrs · Edited



Howaida Elsayed Mansour Yes u are right dr Mohamed Magdy and I'd like to give him large dose steroids and we can start by pulse soluomedrol IV but this boy is just 13 year old in his peak growth spurt. ...I afraid from the effect of steroid on bone growth

Like · Reply · 1 · 5 hrs · Edited



Omer Mala Ahmed Thanks prof **Howaida Elsayed Mansour** for your golden comment , could JIA has minimal swelling & severe tenderness ? The family said that the child has every night fever & rigor which is not typical Quotidian pattern of sJIA ? Its not usual for PSRA to ... [See More](#)

Like · Reply · 1 · 5 hrs



Omer Mala Ahmed Thanks prof **Howaida Elsayed Mansour** for your golden comment , could JIA has minimal swelling & severe tenderness ? The family said that the child has every night fever & rigor which is not typical Quotidian pattern of sJIA ? Its not usual for PSRA to cause additive arthritis ? This very high titer of ASO is not significant ? The child today said still i has cough & white sputum , on examination has few crackles & iam afraid from pneumonia behind his continuous fever & associated rigor !

Like · Reply · 1 · 5 hrs

Aliaa Omar El-hady



Mohamed Magdy I agree with you prof Dr Howaida Elsayed Mansour

Like · Reply · 1 · 5 hrs



Omer Mala Ahmed Thanks prof Howaida Elsayed Mansour , i will update you tomorrow about the pending investigations . If there is no evidence of pneumonia & no evidence of carditis i will change my diagnosis 😊

Like · Reply · 2 · 5 hrs



Howaida Elsayed Mansour In rheumatology the diagnosis and DD are very near...

Like · Reply · 2 · 5 hrs



Omer Mala Ahmed You are right , difficult to decide in some cases 🤔

Like · Reply · 5 hrs



Write a reply...



Mohamed Magdy Serum ferritin

Liver enzymes

CBC again

Chest x Ray

Protein / create ratio

ANA

Like · Reply · 2 · 5 hrs · Edited

Chat (O

Aliaa Omar El-hady



Howaida Elsayed Mansour Dear all , Dear dr Amal El Ganzoury

1- Aspirin is contraindicated in children

2- fever is not at all - part of the clinical picture in reactive arthritis (ReA) either post stryptococal ReA or HLA-B27 related ReA... (one of the SPA) fever only should antידate the arthritis presentation by weeks...thats why this boy is either having infection eg Atypical pnemonia with many extrapulmonary symptoms or systemic onset JIA..

Like · Reply · 1 · 1 hr · Edited



Amal El Ganzoury dear Dr Howaida I know that the pt has a fever it could be part of JIA systemic type or part of the infection the pt suffering from u can't differentiate at that point so I should be a little bit conservative

Like · Reply · 2 · 1 hr



Howaida Elsayed Mansour I mean ReA is not a DD and aspirin is contraindicated in children

Like · Reply · 1 hr · Edited



Write a reply...



Amal El Ganzoury we didn't exclude JIA but it is not definite .so we should consider reactive in addition to the chest infect ion

Like · Reply · 1 · 1 hr



Howaida Elsayed Mansour ReA only follows the infections by weeks not during the acute phase of infections while there is high fever and elevated acute phase reactants. ...etc

Like · Reply · 1 hr · Edited

Aliaa Omar El-hady



Amal El Ganzoury <http://www.nhs.uk/.../Rheumatic-fever/Pages/Treatment.aspx>



Rheumatic fever - Treatment - NHS Choices

NHS.UK

Like · Reply · 1 · November 29 at 5:18pm



Amal El Ganzoury this link illustrate that aspirin is used in rheumatic fever specifically and not contra indicated in such situation pls read

Like · Reply · 1 · November 29 at 5:20pm



Howaida Elsayed Mansour The only indication of aspirin in children is in ttt of acute rheumatic fever "arthritis" but this boy, hasn't rheumatic fever dr.Amal as his arthritis is not fleeting it is of additive pattern ...the secret key of this case is the presence of rigors ...this is very common in bacterimia /pneumonia UTI or SJIA

Like · Reply · 1 · November 29 at 6:50pm · Edited



Omer Mala Ahmed ΔDear progs & doctors

Howaida Elsayed Mansour, Amal El Ganzoury , Rageh M. Elsayed , Basant Esawy , Sherry Kamel , Tamer Elfarahaty ,Hany El-saadany ,Mohamed Magdy...

🕒 Updates Regarding my case .after i putted the child on Amoxiclav & Aspirin

▣ after one day i saw him again about 7pm & he said that i got no fever & no rigor on gone night & my joint pain is better ,but when i checked his temperature it was 38.5 °C !!

▣ Today i saw him again at 5 pm & he said that i got fever & rigor last night after you saw me . & i checked the temperature again today it was 35.5 .

▣ The father said that the child get fever & rigor only at night about 8 pm & not in every night ,Some nights he is very ok . He said that the child never get rashes during attacks of fever & rigor .

▣ EYE Examination : Normal.

▣ Echo Cardiography: Normal.

▣ Abdominal US : Normal (No organomegaly or lymphadenopathy)

▣ CXR: Normal

▣ ECG : Normal

▣ ANA & RF (ELISA) : Negative

▣ S.Ferritin : 216.21 ng/ml (normal value for children 6m-15y is 7-140ng/ml) so it is mildly elevated ▣

▣ Liver Enzymes: Normal

▣ Renal function: Normal

▣ ESR 118

▣ ASO : 1/640

💊 Whats your next future Diagnosis & line of management ?

GREAT REGARDS ▣



Aliaa Omar El-hady



Aliaa Omar El-hady



Howaida Elsayed Mansour Systemic onset JIA

Like · Reply ·  3 · 7 hrs

Case 19

Rageh M. Elsayed

November 29, 2015

13 ys aged girl complains from severe rt, hip pain and limping 2 weeks ago of acute onset and progressive course . 6 months ago the patient has lbp and lt knee after sports activity and subsided with nsiaids and some pt sessions. examination shows obese girl with normal looking no fever no skin , eye , chest or urinary complain, no sij complain, no enthiothopathies no morning stiffness . both lower limb shows shiny hard skin. hip examination shows severe limitation of abduction and internal rotation, while sitting bilateral external rotated feet her lab free and wating HLAB27, ANTICCP, RF, ANA PLZ SEE XRAY FILM for dd and management



TEST		IN RANGE	OUT OF RANGE
ERYTHROCYTE SEDIMENTATION RATE (ESR)	ERYTHROCYTE SEDIMENTATION RATE (ESR)	15	
FUNCTION	SGOT (AST) [V]	35	
	SGPT(ALT) [V]	39	
CREATININE	CREATININE	0.5	
RA FACTOR	RA FACTOR	NEGATIVE	
C REACTIVE PROTEIN (CRP)	C REACTIVE PROTEIN (CRP)	NEGATIVE	
ROUTINE	COLOUR	YELLOW	
	SP. GRAVITY	1.020	
	PH	5.0	
	PROTEIN	NEGATIVE	
	SUGAR	NEGATIVE	
	KETONE	NEGATIVE	
	UROBILINOGEN	NEGATIVE	
	BILIRUBIN	NEGATIVE	
	NITRATE	NEGATIVE	
	LEUCOCYTES	NEGATIVE	
	BLOOD	NEGATIVE	
MICROSCOPY	R.B.Cs	00-02	
	PUS CELLS	01-03	
	EPITHELIAL CELLS	05-08	
	CASTS	NOT SEEN	
	CRYSTALS	NOT SEEN	
	OTHER FINDINGS	BACTERIA [FEW]	

Basant Esawy Nice case dr **Rageh M. Elsayed**

What do u mean by hard skin does it mean sclerosis and to what extension?

What about chest and UL

Could u post the xray ap for both hips

Rageh M. Elsayed Only tight skin looks like of hypothyroid skin

Rageh M. Elsayed



Omer Mala Ahmed Thanks for this nice case dear dr Rageh M. Elsayed , to me the case is Slipped Capital femoral epiphysis , as the X-Ray typical of that condition & this condition is more common in Obese Girls & boys

Rageh M. Elsayed Yes Omer you are right age obese and limited abduction and internal rotation with limping and pain is with SCFE beside typical epiphysis displacement greeting

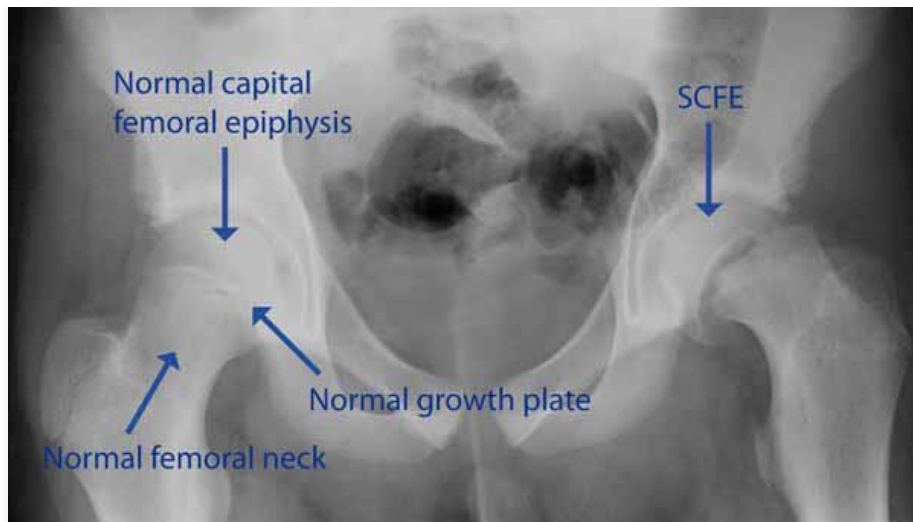
Basant Esawy Does the pt have hypothyroidism ?

Rageh M. Elsayed I requested already free t4 and TSH

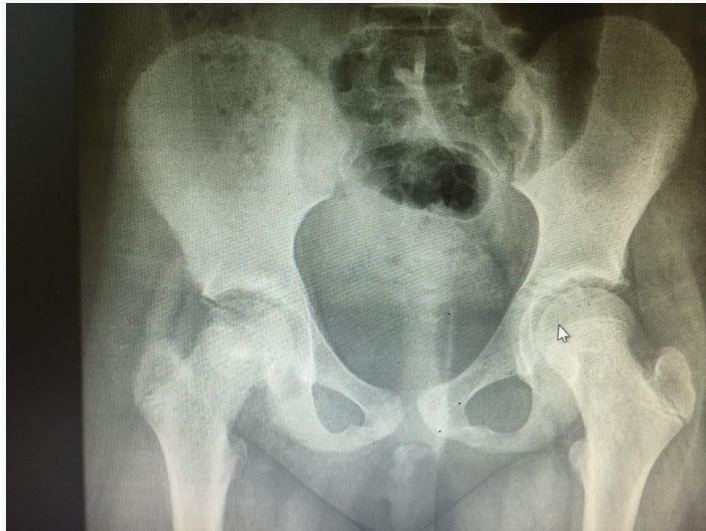
Basant Esawy As the previous pain in the knee and LBP can go with stress fractures

Regarding the xray hip totally agree with dr **Omer Mala Ahmed**

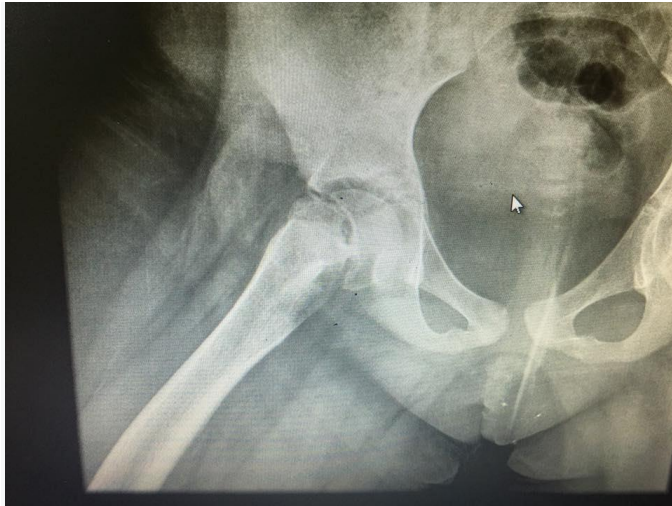
Rageh M. Elsayed SCFE is usually with obese and also associated with hypothyroidism by the way the daughter of the patient had congenital dysphasia of the hip



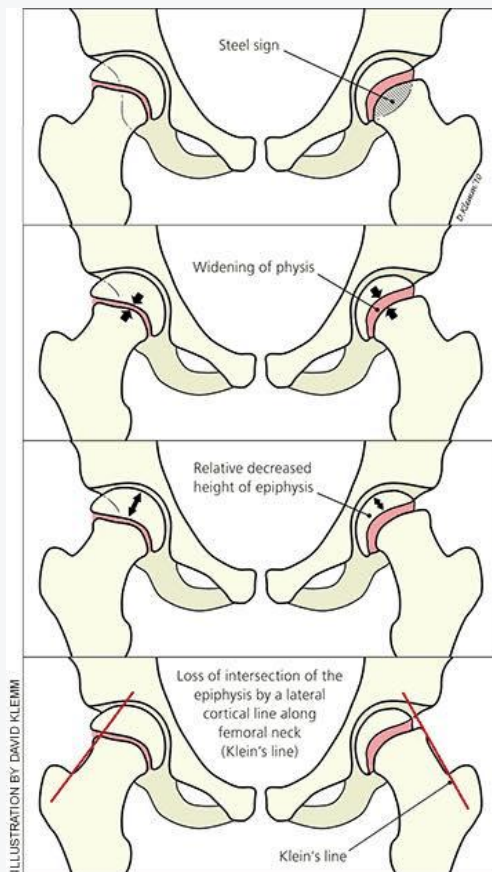
Rageh M. Elsayed



Rageh M. Elsayed



Rageh M. Elsayed



Tamer Elfarahaty Yes ;Clinical and radiolgal picture of SCFE. Assay of vit D may be helpful as Vit D diffecency may be associated with slipped in addation to hypothyroidism.

Aliaa Omar El-hady Thanks Dr. **Rageh M. Elsayed** for your nice case... What is the work with her?? refer to orthopedic surgeon or medical & physical??

Rageh M. Elsayed Yes dr **Aliaa Omar El-hady** urgent pinning is required to prevent further slipping and a vascular necrosis of the hip early interference has good outcome



Aliaa Omar El-hady

جزاك الله خيرا ونفع بعلمك

Tamer Elfarahaty

December 1, 2015

In January 2007, an 80 year-old man, on regular dialysis for 3 years, presented with low back pain which had started 15 days before and fever up to 39° C with chills. His recent medical history was uneventful. His past history included coronary heart disease and hypertension. A right permanent jugular catheter had been placed eight months before and was still used as a vascular access for dialysis.

Two temporary femoral catheters were inserted because of vascular access failure and were used for a few days eight months and twenty three months before.

On physical examination his temperature was 39,3°C. There were no heart murmurs. Applying pressure on the lumbar spine provoked pain. Laboratory studies showed an ESR of 90mm/h, leukocytes 18000/mm³ and CRP 11mg/dl. Blood cultures were negative.

QUESTION 1) - WHAT DOES THE DIFFERENTIAL DIAGNOSIS INCLUDE IN THIS PATIENT?
(ONLY ONE ANSWER IS CORRECT)

- ☒ A) VERTEBRAL BODY OSTEOMYELITIS.
- ☐ B) MALIGNANCY.
- ☐ C) SPINAL TUBERCULOSIS.
- ☐ D) PSOAS ABSCESS.
- ☐ E) ALL OF THE ABOVE.

Tamer Elfarahaty Correct answer : E :all of above

The right answer is E.

In dialysis patients the differential diagnosis of back pain and fever includes all of these conditions. If not accompanied by fever, one should also suspect myofascial pain, renal osteodystrophy or traumatic fracture(1).

Continue

Case 21

Amg Amg

December 6, 2015

Dear professors and colleagues

What's your opinion about this case

Male pt 85 years old presented with pain and limitation of movement both hips more at lt side

ESR 118

urine: pus cells over 100

My DD

septic A

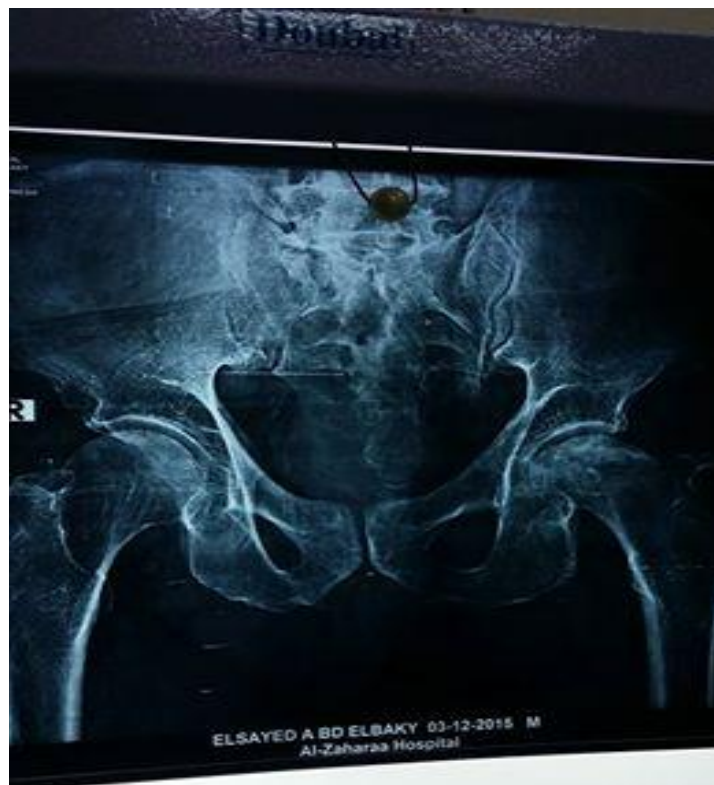
Reactive A

Or paraneoplastic synd

But there is no fever, weight loss

X-ray hips shown

It is AVN?





Aliaa Omar El-hady yes there is AVN on Lt. side (age + very high ESR... we have to exclude paraneoplastic synd especially prostatic carcinoma

Aliaa Omar El-hady **Rageh M. Elsayed** **Howaida Elsayed** **Mansour** **Tamer Elfarahaty** **Muhammad Dughbaj**

Rageh M. Elsayed i need to know how long the complain and associated symptoms back pain night pain vital signs ANY HISTORY OF TRUMA DM HYPERLIPEDEMIA ???? why reactive arthritis ? UTI can cause high ESR WHAT ABOUT CRP ? treat uti and better do culture and sensitivity according to result you can proceed to work up to exclude other cause may need pan CT AND TUMER MARKERS

Amg Amg Dear prof Rageh

One month duration

Pt not diabetic or hypertensive and no history of trauma

Normal vital signs

We requested urine C&S

Rageh M. Elsayed DEAR **Amg Amg** ANY MORNINIG STIFFNESS SHOULDER AFFECTION OR ANY OTHER JOINT AFFECTION

Amg Amg No joint affection

العيان زي الفل مفيش غير الشكوى دي من شهر

Howaida Elsayed Mansour Dear all Dear dr. Amg Amg this is the typical presentation of polymyalgia Rheumatica pelvic girdle pains and very high ESR , in old age one should exclude malignancy specially multiple myeloma bec he has its triad : boney lytic lesions + UTI + anemia in old age with very high ESR , so pls do full CBC, plasma protein electrophoresis, bence Johns protein in urine and urine culture give him calcium + vitD + 10 mg steroids + Ciprofloxacin 500 1x2 for 10 days + do DEXA as he is severely osteoporotic

Amg Amg CBC, liver enzymes, s creat are normal,

Howaida Elsayed Mansour Start ttt while you are doing the workup.

.

Amg Amg Dear prof. Dr howida

We started ceftriaxone injection, NSAIDs

And requested urineCS and MRI pelvis

We will complete the investigations according to your recommendations

Howaida Elsayed Mansour Good start but add low dose steroids bec polymyalgia Rheumatica is essentially ttt by steroids and we may add immunosuppressive therapy after excluding malignancy

Amg Amg OK

thanks alot our dear prof.

May Allah bless your life

Muhammad Dughbaj DD (AVN) (INFECTIOUS ARTHRITIS)



Howaida Elsayed Mansour Dear dr. **Muhammad Dughbaj**

1- Infectious arthritis or septic arthritis is a monoarthritis not polyarthritis 2- even if there is avascular necrosis of femoral head that appears as lytic areas or collapsed head , in this age all this might be secondary to malignancy and if you added all this to UTI and severe osteoporosis multiple myeloma (MM) will be on the top of the list..

Muhammad Dughbaj Normal vital signs normothermic in old age is not uncommon in septic arthritis (specific or non specific) , needs CBC WBC total and deferential , PCT TEST procalcitonin test can point to bacterial infection ,Bone scan especially LEUKOSCAN is now more specific to detect bone infection in addition to the list of respected Prof**Howaida Elsayed Mansour**

Rageh M. Elsayed DEAR DR howaida no criteria till now for PMR

Howaida Elsayed Mansour Pelvic girdle pain and stiffness in an 85 years old man with very high ESR 118 and high CRP this is more than enough dear dr Rageh M.Elsayed ; if we didnt put PMR as a provisional diagnosis here we will never diagnose PMR ...

Muhammad Dughbaj Dear Prof Dr **Howaida Elsayed Mansour** the history is pain and limitation of movement (not stiffness) x ray no involvement of Rt hip only collapse of the left hip

Howaida Elsayed Mansour Dear all, if we didnt suspect PMR as a paramalignant syndrome in this patient, this would be a

great mistake.. . This is not at all- a final diagnosis but a serious provisional diagnosis that should be ruled out this is much better than taking the case as simple as idiopathic AVN or ReA ...in such age and missing a serious disease...!!

It is important for the junior doctors to know how one should think and proceeds in rheumatology cases "each case has its key to diagnosis". Again we will not lose anything if we ruled out such a serious disease this would be much better than missing it...!!

2- We don't depend on the xray only in diagnosing the patients - history is the most important diagnostic tool, he has bilateral hip pain more to the lt side and we all know that stiffness is typically associated with limitation of movement ...most patients can't differentiate between limitation of movement and stiffness. .!!

Tamer Elfarahaty Yes xray shows picture of AVN of left side with narrowing of inferior pole of hip joint consistent with patient complaint (hip pain and limitation of movement). Ask about therapeutic history of CCS which may be related to osteonecrosis & severe osteoporosis). History of liver disease ; other joints & back pain . ESR often increase with old age and may be UTI induced but very high ESR (repeat it) may be alarm of malignancy . Ist treat UTI according to culture sensitivity . request CRP. Routine full CBC; liver enzyme; serum vit D ;amylase and serum UA (increase with Mg like Multiple myeloma). Work up to rule out malignancy(Severe osteoporosis may be a manifestation of underlying malignancy)

Case 22

Case study

حالة عرضتها ا.د. هويدا منصور في احدى المؤتمرات مع علاجاتها... وتفضلت
وهذا ما فيها power point سيادتها بانزالها ك

Howaida Elsayed Mansour

Abeer, a 39 years old female patient , house wife , from Tokh -
kaluobeia married and has four children, she is non smoker and
has irregular menstrual cycles with no special habits of medical
importance .

Complain of diffuse skin tightness and hardening of one year
duration.

HPI : The condition started 8 years ago by recurrent attacks of
sore throat, dyspnea, orthopnea and paroxysmal nocturnal
dyspnea, for which she was investigated and was found to have
rheumatic mitral valve disease (MS).

She underwent a successful Mitral valvoplasty by balloon
dilatation she was improved and has been kept on regular
monthly penicillin injections.

Two years later she experienced progressive skin tightness that
involved the proximal parts of the upper and lower limbs.
The stiffness involved both arms, shoulders, thighs, the whole
back region including the back of the neck and it also involve
the checks.

The skin tightness was progressive and associated with sense of
heaviness of the arms, shoulders and the thighs ,easy fatigability
and walking difficulty.

There was no Raynaud's phenomena, dysphagia, arthralgias or
arthritis.

No hands, fingers or toes affection.

No fever, butterfly rash, oral or genital ulcers.

Past history irrelevant.

Family history irrelevant.

EXAMINATION:

She is normal looking, overweight female, oriented of average mood and intelligence.

There is extensive diffuse skin stiffness and hardening ; thighs, arms, trunk and the back but hands and feet were spared...

Investigations:

CBC normal

-Urine analysis normal

CRP –ve

-ANA , anti-DNA negative

ESR 11

-Normal pulmonary functions.

ASOT 600 Todd units

- CPK ,AST,ALT were normal

FBG 80 mg%

Plasma protein electrophoreses is normal.

HRCT chest normal

- Echo dilated Lt. atrium, moderate MS

التحاليل مرفقة فى الكومنتات

Provisional diagnosis

You don't have Scleroderma.....!!

What was clinically against Scleroderma ??

1- The skin tightness is sparing the fingers and hands.

2- No Raynaud's phenomena...

3- No local or systemic signs of inflammation

4- Normal lab. systemic inflammatory markers :

ESR ,CRP, negative ANA testing...

فى الكومنتات scleroderma criteria مرفق ال

فى الكومنتات skin biopsy مرفق تقرير وصور

Three differentiating histopathology points between Scleredema and scleroderma:

“Unlike Scleroderma”

- 1- The excessive collagen bundles are not infiltrated by inflammatory cells but they are separated by excessive mucinous substance “Skin mucinosis”
- 2- The eccrine sweat glands in the dermis are surrounded by fat cells while fats are completely absent in scleroderma.
- 3- The excessive collagen fibers are not extended to the subcutaneous tissue.

سcleredema presentation مرفق صورتين

“Scleredema” it is a skin disease in which there is an abnormal deposition of collagen and mucinous substance into the dermis.

There are three types of Scleredema:

- 1- Type 1 ; post infectious “Scleredema Adultorum of Bauschke” it usually follows upper respiratory tract streptococcal infection (typically pharyngitis).
 - 2- Type 2 ; associated with plasma dyscrasia eg multiple myeloma or monoclonal gammopathy.
 - 3- Type 3 ; “Scleredema diabeticorum” it occurs usually in obese men with uncontrolled type II diabetes.
-

?? Treatment:

- MTX 15 mg / week, low dose steroids 5-10 mg daily, hydroxychloroquine 200 mg daily
- Alendronate 70 mg tab once / week
- Reassurance

صورة لظهر المريضة بعد التحسن في الكومنتات

Important message

Rheumatology is a clinical diagnosis ; Listen carefully and give time to your patient.

Not every skin tightness / stiffness is scleroderma.

Before diagnosing your patient as scleroderma be sure that she is not having an overlap syndrome or MCTD...



Aliaa Omar El-hady

1st Lab Clinical Laboratory

مركز أبحاث الطب

1st

مركز أبحاث الطب

PATHOLOGY REPORT

Reg. No.: 1585 - (1084182) Patient Name: عيبر أحمد محمد
Age: 38 Y. Sex: Female Date Report Issued: 13/7/2013

CLINICAL DATA: A case of scleroderma, and calcinosis.
SPECIMEN: Skin biopsy.

GROSS PICTURE: Greyish piece measured 1.5x1 cm.

MICROSCOPIC PICTURE: Serial sections examined revealed atrophic epidermis, loss of rete ridges, dermal fibrosis with patchy hyalinosis.

DIAGNOSIS: Skin Biopsy:
➤ Findings Are Compatible With Clinical Diagnosis Of Scleroderma.

SIGNATURE
Dr. Ahmed Abd El-Aziz
Professor of Pathology
Faculty of Medicine, Cairo University

NOTE: This report was generated by computer, any manual correction will make it null and void.

مركز أبحاث الطب، ٤٦ شارع محمد الدين، أبو العز، الدقي، ت. ٢٢٢٠٩٣٠٠٠ (خطوط ١٠٠) ف. ٢٢٢٠٩٩٩٩ محمول: ٠١١٩/٨٠١٧٥٠٠٠
أكثر من ٣٠ فرع في خدمتكم

Aliaa Omar El-hady

Patient Name : عبير أحمد محمد يونس
Patient Number : 24- 50741
Ref. Doctor : د. -
Specimen : Biopsy consultation
Reporting Date : 23/07/2013

Report

Gross Picture:

A paraffin block
No. 1585, for sectioning and histopathological assessment and
Re- inclosed.

Microscopic picture:


Section examined revealed skeletal muscle biopsy showed
vacuolated muscle fibers which are separated from each other
by edema and focal collection of inflammatory cells. Increased
wavy collagen fibers are detected . capillaries showed intimal
proliferation with focal lumen narrowing with thickening of
adventitial covering .

- Perivascular edema with mild , chronic inflammatory
cells.
- Focal muscle calcification is observed

Diagnosis:

Muscle biopsy :-

- Features are suggestive of scleroderma.
- For immunologic marker (ANA).
- Please , correlate clinically .
- No malignancy.


Dr. Gamal Selim , MD.

Call Center 16191

عامل الفا

A MEMBER OF ALFA MEDICAL GROUP

Aliaa Omar El-hady

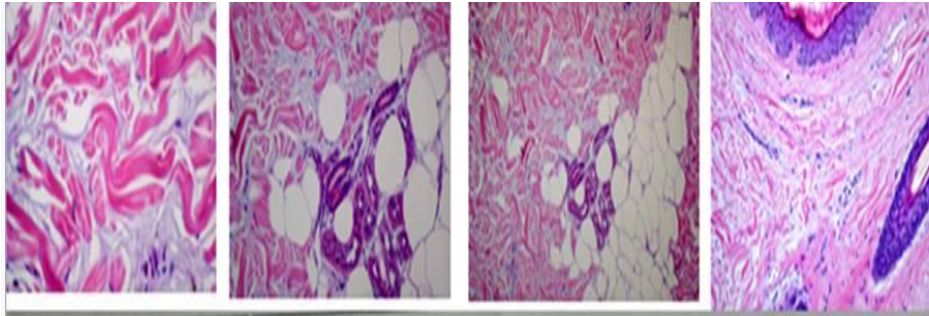
2013 ACR / EULAR Criteria For The Classification Of Systemic Sclerosis (Scleroderma)*

Item	Sub-items(s)	Weight/score [†]
Skin thickening of the fingers of both hands extending proximal to the metacarpophalangeal joints (<i>sufficient criterion</i>)	-	9
Skin thickening of the fingers (<i>only count the higher score</i>)	Puffy fingers	2
	Sclerodactyly of the fingers (distal to the metacarpophalangeal joints but proximal to the proximal interphalangeal joints)	4
Fingertip lesions (<i>only count the higher score</i>)	Digital tip ulcers	2
	Fingertip pitting scars	3
Telangiectasia	-	2
Abnormal nailfold capillaries	-	2
Pulmonary arterial hypertension and/or interstitial lung disease (<i>maximum score is 2</i>)	Pulmonary arterial hypertension	2
	Interstitial lung disease	2
Raynaud's phenomenon	-	3
SSc-related autoantibodies (anticentromere, anti-topoisomerase I [anti-Scl-70], anti-RNA polymerase III) (<i>maximum score is 3</i>)	Anticentromere 3 Anti-topoisomerase I Anti-RNA polymerase III	3

* The criteria are not applicable to patients with skin thickening sparing the fingers or to patients who have a scleroderma-like disorder that better explains their manifestations (e.g., nephrogenic sclerosing fibrosis, generalized morphea, eosinophilic fasciitis, scleredema diabeticorum, scleromyxedema, erythromyalgia, porphyria, lichen sclerosis, graft-versus-host disease, diabetic cheiroarthropathy).

† The total score is determined by adding the maximum weight (score) in each category.
Patients with a total score of ≥ 9 are classified as having definite scleroderma.

Sensitivity 91% Specificity 92%



MICROSCOPICALLY :

Sections examined revealed an intact slightly flattened epidermal covering. The upper dermis shows unremarkable perivascular mononuclear cell infiltrate. The upper dermis is markedly thickened by hypertrophied collagen bundles which are separated by pale basophilic mucinous substance causing fenestration of the collagen. This lesion extends to involve the mid & lower dermis but not involving the underlying subcutis. The eccrine glands are almost normal in position (between mid and reticular dermis) and still surrounded by fat cells. A picture is consistent with scleredema.

The muscle tissue examined is slightly oedematous showing loss of striation in foci which may be ascribed to systemic effect of the skin lesion of scleredema

DIAGNOSIS : Skin biopsy







Cutaneous mucinosis consistent with scleredema.



NB:

- In contrast to scleroderma, no cellular lymphoplasmocytic inflammatory infiltrate between the collagen bundles, but there is mucinous substance.
- No extension of the lesion to the subcutaneous tissue as in scleroderma.
- The eccrine glands are surrounded by fat cells in scleredema, but the fat is completely absent in scleroderma and instead it is surrounded by collagen bundles.

Sh
PROF. DR. SHADIA MABROUK

Aliaa Omar El-hady

emedicine.m

**Medscape**

DRUGS & DISEASES

Scleredema Presentation





HistorySections +

Patients report stiff or hard skin. The rapidity of onset and locations of involvement differ based on the clinical subgroup.

Scleredema can be categorized into 3 clinical subgroups. Each has a different history, course, and prognosis. Note the following:

- Type 1, postinfectious: This subgroup was historically referred to as scleredema adultorum. However, this is considered by some to be a misnomer because most pediatric patients fall into this group. Patients report a hardening of the skin a few weeks after a febrile illness, most commonly an upper or lower respiratory tract streptococcal infection.^[15] The skin hardening progresses rapidly, first involving the face and neck, then spreading distally to involve the trunk and proximal upper limbs in a symmetric manner. Hands and feet are typically spared. Complications may include difficulty in smiling, opening the mouth, limited range of motion, and, in severe cases, involvement of the pharynx or tongue can lead to dysphagia or dysphonia. The condition usually clears spontaneously in 6 months to 2 years. The duration is not affected by the use of antibiotics.
- Type 2, associated plasma dyscrasia: This subgroup includes patients whose disease tends to occur

[Aliaa Omar El-hady](#)

← →  **emedicine.m**   

and, in severe cases, involvement of the pharynx or tongue can lead to dysphagia or dysphonia. The condition usually clears spontaneously in 6 months to 2 years. The duration is not affected by the use of antibiotics.

- Type 2, associated plasma dyscrasia: This subgroup includes patients whose disease tends to occur insidiously, progressing slowly over many years, with no history of preceding illness. Rimon et al identified 52 cases of type 2 scleredema in the world literature from 1963 to 1986, of which 25% had plasma cell dyscrasias, including 3 with multiple myeloma and 10 with monoclonal gammopathy of unknown significance. They also noted that the gammopathies were diagnosed on average 10 years after the onset of scleredema skin changes.^[9] IgG monoclonal gammopathy is most common, followed by an IgA type. Spontaneous remission is much less likely to occur than in the type 1 subgroup.
- Type 3, associated diabetes mellitus (scleredema diabeticorum): This subtype of scleredema tends to occur more often in middle-aged males (at a reported 10:1 ratio), often obese, with longstanding, often uncontrolled, type 1 diabetes mellitus. Subtle skin hardening of the upper back begins in an insidious manner, progressing slowly over many years, to involve the upper back, neck, and shoulders with associated erythema; often, a pebbled appearance may evolve. Patients typically experience a more protracted course that is refractory to therapy. Control of the hyperglycemia does not improve the scleredema.^[16]

A thorough history regarding preceding illnesses, history of diabetes, and a review of systems should be performed to help identify less commonly associated extracutaneous manifestations (lungs, heart, trouble eating or talking, or muscle weakness) or rarely reported associations with

[Aliaa Omar El-hady](#)

المریضة بعد التحسن



[Sherry Kamel](#) What is the role of aldorelate in scleredema???.prof [Howaida Elsayed Mansour](#)

Howaida Elsayed Mansour Nice question dr.**Sherry Kamel** actually alendronate is famous for mobilizing and dissolution of abnormal subcutaneous ectopic calcification that occurs due to excessive tissue deposition of Ca (I remember this pt was having excessive Ca crystals deposition in the derms in skin biopsy report) so to mobilize this back to the blood or the bone alendronate should be given, this is true also in Crest syndrome or any subcutaneous calcifications as in some cases of polymyositis /Dermatomyositis. .

Howaida Elsayed Mansour

وشكرا ليكم جميعا والمريضة دي بتابع معايا لسة لغاية dr.**Sherry Kamel** شكرا دلوقت بشوفها كل شهرين تقريبا وكم ان بتابع مع د القلب وهي كويسة اوي ؛ بس ايه اللي فكرت بالحالة دي دلوقتي يا د شيري..

Sherry Kamel

بمناسبة اننا عاملنا جروب جديد للحالات ومناقشتها... فأکید لازم نفكر حالات حضرتك الجميله والمميزة

Omer Mala Ahmed

December 10, 2015 · Ranya, Iraq

♻️ 55 years old female patient today presented to me complaining of bilateral knee pain & limitation of flexion with minimal swelling of more than 1 year duration.

❑ INVESTIGATIONS:

CBC : Normal

ESR : 30

CRP: -ve

RF; -ve

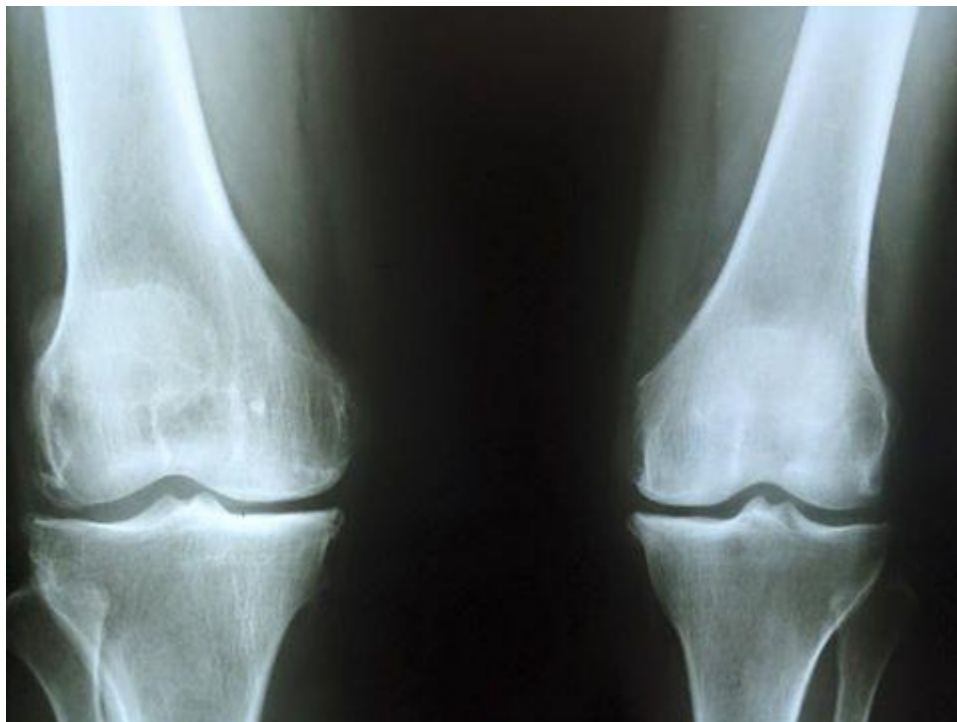
❑ she was putted on MTX by a professional Rheumatologist & told her that a Rheumatological disease is behind her knees condition !

♻️ Can anybody give an idea about this situation?

▪ I see just an OA changes involving both medial & lateral knee compartments which may behind putting her on MTX .





Could if we see an OA changes involving the knee uniformly (not focal) means that there is an inflammatory disease behind these changes ?

Regards



[Aliaa Omar El-hady](#) Its to me just knee OA
[Omer Mala Ahmed](#) Dear profs & Doctors
[Howaida Elsayed Mansour](#) , [Sherry Kamel](#) , [Basant Esawy](#), [Tamer Elfarahaty](#), [Rageh M. Elsayed](#) , [Mona Mansour](#)

[Wajeih Mahmood](#) according to ACR criteria >>> she has not yet fulfill neither the 1988 nor the 2010 criteria

RHEUMATOID ARTHRITIS DIAGNOSIS CRITERIAS			
Old criteria (ACR 1988)	Information source	New criteria (ACR –EULAR 2010)	
Symmetric peripheral polyarthritis		1 large joint	0
Arthritis of ≥3 joint areas		2 – 10 large joints	1
Arthritis of hand joints		1 – 3 small joints (with or without involvement of large joints)	2
Rheumatoid nodules		4 – 10 small joints (with or without involvement of large joints)	3
		>10 joints (at least 1 small joint)	5
Serum rheumatoid factor	 	Negative RF and negative Anti-CCP	0
		Low-positive RF or low-positive Anti-CCP	2
		High-positive RF or high-positive Anti-CCP	3
Radiographic changes		Normal CRP and normal ESR	0
		Abnormal CRP or abnormal ESR	1
Morning stiffness ≥ 1h		< 6 weeks	0
		≥ 6 weeks	1
4 of 7 criteria are needed	<div> <div>←</div> <div>Late diagnosis</div> <div>Early diagnosis</div> <div>→</div> </div>		A score of 6/10 is needed for classification of a patient as having definite RA

[Rageh M. Elsayed](#) Good pm dear [Omer Mala Ahmed](#) nice common presentation from x Ray1- I noticed valgus deformity 2- tilted patella esp rt side meaning external rotation of tibia and femur I am asking if the patient obese or has pes plans 3- any hip complain 4- for me it is mechanical(PFOA) not inflammatory as role after excluding inflammatory arthritis any middle joint as knee you must exclude any problem of proximal and distal joints (here hip and ankle) 5- regarding patellar displacement can affect flexion ROM 5- search for muscle imbalance around knee as tight ITT and weak VMO Tight hamstring and weak quadriceps and gluteus Maximus weak adductor and tight TFL

Omer Mala Ahmed Thanks for your informative comment dear **DrRageh M. Elsayed** , really she is no Obese & has normal hips & plantar arches .

What made me thinking is that : there is uniform narrowing (both medial & lateral compartments) & on the basis of this finding the Rheumatologist putted her on MTX (inflammatory arthritis not specifically RA) !?!

Rageh M. Elsayed Recent studies using MTX in OA showed modest improvement in pain not in function beside all these patients were under NSAIDs while using MTX

Rageh M. Elsayed Does Methotrexate Improve Osteoarthritis Pain? - Medscape

www.medscape.com › viewarticle

Mobile-friendly - Feb 18, 2015 - Methotrexate (MTX), the most common initial DMARD used in RA, has been a mainstay of treatment ...



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Tamer Elfarahaty For me : just knee OA. MTX is no ta first line for treament of OA . It's prescription is not on radiological background . It may be used in resistant or recurrent synovitis with OA which detected clinically or by US. Some studies since 2013 mentioned MTX as an effective in knee OA especially with synovitis. Cytokines (TNF ; IL 1) play a role in OA

pathogenesis and initiate immune response and this may explain the option of use MTX in knee OA.

Basant Esawy How to DD OA from RA in the knee?

In RA it is bi-compartment affection and even in presence of secondary OA there will be no sclerotic margin which still preserved in ur case no erosions and no JAO

In atypical RA rapidly progressive joint space narrowing and Juxta articular osteopenia +/- erosions with presence of AcPA and or RA high titer > 6 w and abnormal CRP and or ESR

So your case is OA not RA

Adrozy Al-Adrozy is there an element of CPPD

Basant Esawy No chondrocalcinosis in the xray but still DD and can be detected early in the knees by MSKUS before conventional xray

Also you can check in triangular cartilage of the wrist

Basant Esawy

< HOME ACR-EULAR criteria

A. Joint involvement

(L: Large joints*, S: Small Joints**)

1L

2-10L

1-3S

4-10S

>10

B. Serology (R: RF, A: ACPA)

-: negative, +: Low-positive, ++: High-positive

R- & A-

R+ or A+

R++ or A++

C. Acute-phase reactants

(C: CRP, E: ESR)

Normal C & E

Abnormal C or E

D. Duration of symptoms

<6 weeks

≥6 weeks

Score 6/10 Definite RA

*Large joints: shoulders, elbows, hips, knees, ankles

**Small joints: metacarpophalangeal joints

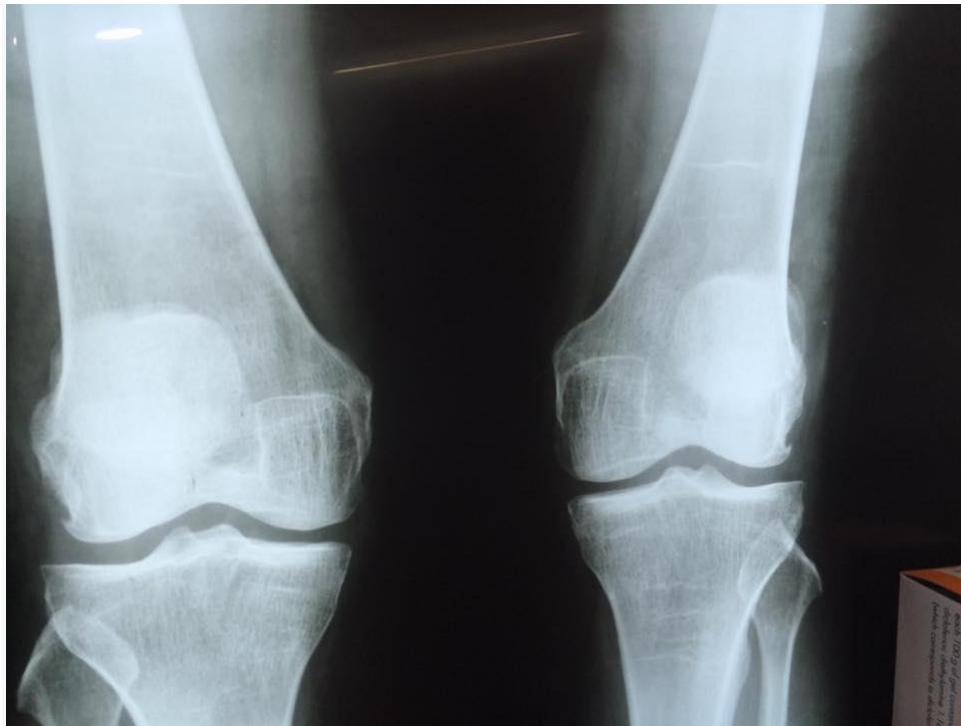
proximal interphalangeal joints

2nd~5th metatarsophalangeal joints

thumb interphalangeal joints, and wrists

Omer Mala Ahmed Dear colleagues the rheumatologist treated her as an inflammatory arthritis not as RA , because he found that all the compartment of the knee are affected (medial & lateral) , not focal as seen in OA which usually affects the medial one

Omer Mala Ahmed Whats you opinions about this X-Ray with Unusual evidence of isolated lateral compartment OA changes without evidence of chondrocalcinosis which is usually it behind the lateral compartment knee OA changes ?!



Basant Esawy There is affection in both compartment but the affection more in the medial aspect , plus sclerosis against RA even in presence of OA , no JAO and no erosion
Clinical point of view u should apply criteria if u have 2 large tender swollen j with the previous parameter as high AcPA /Rf with high CRP / ESR in duration more than 6 w you can suspect atypical RA

Still CPPD is DD by MSKUD , check the wrist also

Omer Mala Ahmed What your opinion Dr Basant regarding the posted X-Ray in the comments with just evidence of lateral OA ?

Basant Esawy yes dr **Omer Mala Ahmed** it is mostly OA as I justified before as it is more medial with sclerosis
U can r/o associated CPPD

Howaida Elsayed Mansour Dear dr. Omer Mala Ahmed dear all,
a part from the fact that we sometimes use DMARDS in

resistant OA - the presence of xray changes of OA doesn't mean that the patient has OA.. as she might have gout or pseudogout and this is the cause of her pains, even if there are xray changes of OA (65% of people above the age of 50 have xray changes of OA but they are asymptomatic) ..just check for serum uric acid or any +ve family history . This x ray shows only early OA with some effusion, periarticular osteopenia and genu valgus, I need to know is there 1st MCPJ pain or any hand pains or limitation of movement ? I need to see a photo for the knees....for me if she was not responding to chondroitin sulfate compounds or DMARDs I would go to synovial fluid aspiration and WBC count + local injection of two vials of dexamethasone 40 mg (therapeutic and diagnostic)

Mona Mansour This reminds me of an opposite case whom I diagnosed RA and was previously diagnosed OA , she did a total knee replacement for one knee and had an effusion in the other side, she has long standing foot deformity that developed gradually by time also Mild swelling and tenderness of hand joints. Her ortho dr suspected RA but the lab revealed -ve RF and anti CCP antibodies. Her ESR. And CRP showed mild elevation, but he diagnosed it as RA. In view of her knee effusion , mild affection to hand and wrist affection I requested ultrasound of her hands which confirmed RA by the presence of erosion and synovial hypertrophy. So I gave her combination DMARDs and she is improving. So if there is doubt in seronegativity cases better to request ultrasound hands . But my guess is that your case is OA knee.

Tamer Elfarahaty MSKUS is better to detect CPPD as synovial fluid of OA patients may contain CPPD or hydroxyapatite crystals. too small to detect by routine microscopy . Also ,Valgus knee deformity is specially suggestive of underlying CPPD.

Omer Mala Ahmed Dears all , thanks for your comments & informative discussion.

Unfortunately we have no professional MSK US practitioners & we have no polarized microscope for finding crystals, that's why I should depend strictly on clinical & some lab results & X-

ray findings.

Dear prof [Howaida Elsayed Mansour](#) really she had no any evidence of hand joints synovitis & unfortunately I didn't took her knee pictures. She had no history of feet joints arthritis or podagra.

What remained questionable are:

if there's uniform joint space narrowing with sclerosis of borders & osteophytes ; it means that it may be an inflammatory arthritis behind the condition, especially if we have no further facilities like MSK US or polarized microscope?

as all of you know that OA mainly affect the medial compartment of the knee with genu varum deformities, but if the lateral compartment is mainly affected with the consequent genu valgus deformity without evidence of chondrocalcinosis on plain X-Ray ; is that mean that there may be hidden CPPD behind this condition? Or it's usual for OA knee to affect the lateral compartment mainly ?

Great regards

[Howaida Elsayed Mansour](#) OA can affect any compartment of the knee and sometimes can cause genu valgus deformity but there might be underlying pseudogout if there is no improvement on OA ttt and persistent bilateral knee effusion

Case 24

Omer Mala Ahmed

December 10, 2015 · Ranya, Iraq

♻️ 60 years old man , known case of Gout, visited me today presented to me with severe pain+ swelling & redness over the medial aspect of left 1st MTP joint for 3 days duration , I tried to aspirate & on aspiration i found a cheesy white fluid came in to the syringe !□

NOTE : because of excessive attacks of arthritis i putted the patient on life long Allopuranol (300mg/day) + colchicine for 3 months & his S.Uric acid was controlled below 6mg ,but the patient stoped the drug for long time when he improved from arthritis & he eat excessive meat □

■Any Further informative updated comment regarding Gout ?





Aliaa Omar El-hady you have to do culture & sensitivity...
may be abscess versus inflamed tophi

Sherry Kamel dear dr. **Omer Mala Ahmed**, you can change the
allopurinol to febuxostat (Xanthine oxidase inhibitor), it is more
effective to decrease frequency of gouty arthritis plus
colchicine

Case 25

Aliaa Omar El-hady

December 8, 2015

Case presentation - مقدمة من د. **Mohamed Magdy**

Female patient , 25 ys old
Lived at Monieb city

Single

Stay in her home without working

Has no special habits of medical importance .

Complain:

Fever and generalized bony aches 7 days ago.

History of present illness:

The patient came to out patient clinic with fever of acute onset , gradual course that increase at the evening reach about 39 , not corrected with antipyretics.

There is no recent infection , no open wound , no sore throat or changes in the bowel of the patient.

There is no swelling in her breast or under the axilla or any lymph nodes enlargement.

The fever accompanied with generalized bony aches , with swelling in her ankle joints that become painful , hotness and limited range of motion.

Also , there is poly arthralgia in the small joints of both hands especially in the distal interphalangeal joints of both hands and both wrists.

There is no dyspnea or difficult in breathing or symptoms suggesting chest affection .

There is no symptoms suggesting cardiac affection .

There is no symptoms suggesting GIT affection , no diarrhea or presence of blood in stool or dysphagia .

The patient known as a case of psoriasis that diagnosed 12 ys ago , there is generalized psoriasis all over the body , especially in the dorsum of the both hands , both LL, the back, the scalp and under her breasts, and controlled by topical medication.

4 months ago, the patient complain pain and swelling in the small joints of both hands especially distal interphalangeal joints and MCPs and both wrists ,both ankles and both knees but no inflammatory LBP or sacroilitis , the patient diagnosed as psoriatic arthritis and controlled by methotrexate (12.5 mg per week).

The patient admitted in our hospital and complete examination and routine investigations were done .

The positive data :

The patient is very conscious , oriented to time , place and person

ABP: 110/70 mmhg

Temp : 38

RR:16

HR: 80 beat / minute

the patient is pale but no cyanosis or jaundice

No congested neck veins or thyroid enlargement or LN enlargement.

There is erythematous , scaling plaques on the scalp , trunk and both upper and lower limbs were observed.

Dermatological consultation :

Psoriasis area and severity index (PASI) : 16.6

Histopathology of skin biopsy show : psoriasis vulgaris.

there is arthritis in PIPS , MCPs and both wrist joints.

There is arthritis in both knee joints.

there is arthritis in both ankle joints

The result of investigation :

CBC show:

Hb: 6.9

TLC : 3.8 with lymphopenia

Platelets : 130

Coombs test : positive

ESR : 140

CRP : Negative

Urine analysis : NAD and protein in 24 hr was done.

ANA , anti DNA , C3 , C4, anticardiolipin were done.

We decide that : the patient should take blood transfusion that already done and the Hb raise up to 8.2 and TLC : 4.6

According to the ACR criteria of SLE , the patient fulfill more than 4 items , the patient has:

1-Arthritis in the small joints of both hands , both wrists , both knees and both ankles.

2- pancytopenia and lymphopenia

3- ANA positive

4- anti ds DNA positive

5- C3 and C4 consumed.

So , the patient diagnosed as psoriatic arthritis overlapped with SLE

Discussion:

The etiology and pathogenesis of psoriasis are not yet clearly understood, but the condition is thought to be related to a polygenic predisposition and a number of environmental trigger factors, such as stress, trauma, infection, and drugs. While the model of inheritance for psoriasis is quite complex, Several genes that confer increased susceptibility to psoriasis have recently been identified, among which the PSORS gene complex (1 to 9) is of particular interest.

Psoriasis shares both immunologic and genetic risk factors with other autoimmune diseases such as the connective tissue diseases RA and SLE. Previously, CD4 helper T (TH) 1 cells were considered to be the most important cells in the pathogenesis of these diseases, but greater importance is now given to the role of TH17 cells, a novel CD4 T effector cell that plays an important role in many autoimmune diseases .

Until a few years ago, only 2 types of such cells were known (TH1 and TH2), but a third type TH17 has now been identified. TH1 cells intervene in the development of CD8 cells and TH2 cells are responsible for the antibody-mediated immune response, while TH17 cells are implicated in the autoimmune inflammatory response. Naive TH cells differentiate into specific types depending on the stimulus they receive . Differentiation into TH17 cells is mediated primarily by transforming growth factor- β , while IL-23 contributes to the survival and proliferation of these cells. IL-23 concentration is

elevated in psoriasis lesions and decreases when the lesions respond to treatment, revealing a direct correlation between overproduction of IL-23 and active psoriasis. It has been suggested that the IL-23/TH17 axis may play a fundamental role in the pathogenesis of psoriasis .

The main cytokines secreted by TH17 are IL-6, IL-17, IL-21, and IL-22; the last 2 induce keratinocyte hyper proliferation. Moreover, it is thought that IL-21 may also act as a feedback mechanism stimulating production of TH17 cells. The most recent theories posit that therapies targeting IL-23 alone would be sufficient to improve psoriasis, but some authors have suggested that neutralizing IL-21 in vivo by means of soluble receptors or monoclonal antibodies could be a useful tool in the treatment of psoriasis.

This etiologic and pathogenic complexity is not exclusive to psoriasis and, in fact, it would appear that TH17 cells, as well as IL-17 and IL-23, are also implicated in SLE, although the role of these cytokines in humans is poorly understood because most studies to date have been carried out in mice. In fact, elevated TH17-cell serum concentrations have been observed in some patients with SLE; IL-17 and IL-23, which may contribute to the renal damage, have also been detected in the kidneys of patients with lupus nephritis.

Since reductions in the production of IL-17 in mice have been correlated with clinical improvement, it has been proposed that anti-IL-17 therapy could be useful in the treatment of patients with elevated serum levels of this cytokine. IL-21 levels are also elevated in the serum of these patients, although in this case there is no apparent correlation with disease severity.

SLE is associated with various autoimmune diseases, such as RA, Sjögren disease, Hodgkin disease, and Crohn disease.

However, the association of SLE and psoriasis is very rare. The mechanisms involved in this association are poorly understood, but it is thought that there must be a common immunologic basis. T cells play a primary role in the pathogenesis of psoriasis while B cells appear to be central in SLE, giving rise to the view that superantigens might be the common mediator. However, it

is now known that alterations in the TH17 cell pathway occur in both diseases.

In their typical forms, psoriasis and SLE are easily differentiated. However, the differential diagnosis can sometimes be difficult because the clinical spectrum, mainly of SLE, is very broad. The LE lesions most often confused with psoriasis lesions are those caused by subacute lupus, a disorder in which psoriasiform lesions have been reported in 15% to 50% of patients. Cases of SLE associated not only with classic psoriasis skin lesions but also with psoriatic arthritis have recently been reported; this association has implications for differential diagnosis, treatment, and prognosis.

Choice of treatment is the main problem in patients with concurrent SLE and psoriasis.

1- UV radiation, one of the principal treatments for psoriasis, can trigger and worsen SLE. Although the outcome is favorable in most cases, toxic epidermal necrolysis has been reported in a patient treated with UV-B for psoriasis who had a history of SLE.

2- Antimalarial agents (hydroxychloroquine, chloroquine) are among the drugs most often used to manage both cutaneous and systemic LE, and it is well known that these drugs can trigger or aggravate psoriasis. In vitro studies have shown that hydroxychloroquine produces hyperproliferation and irregular keratinization in skin taken from patients with psoriasis. However, cases have been reported in which the course of psoriasis was not altered when hydroxychloroquine was prescribed to patients with concomitant SLE

3- Another treatment-related problem is the risk of triggering a severe psoriasis flare when systemic corticosteroids are prescribed to manage SLE.

In theory, the systemic use of corticosteroids would be contraindicated in patients with psoriasis owing to the possibility of psoriatic erythroderma.

4- Drugs that inhibit TNF- α (anti-TNF- α agents) are currently one of the main treatments for severe psoriasis. These drugs have been somewhat effective when occasionally used to treat patients with SLE, but there have been reports of exacerbation of SLE following their use, most often in the case of infliximab and etanercept. These reports raise the question of whether SLE is a contraindication to the use of anti-TNF agents. Drug-induced lupus, sometimes involving anti-TNF- α agents, has also been described. However, some authors believe that TNF inhibitors give rise to a very specific clinical picture known as anti-TNF- α -induced lupus .

Anti-TNF- α -induced lupus (ATIL) a much less common entity than drug-induced lupus and one with different characteristics. ATIL is characterized by a higher incidences of hypocomplementemia and high titers of anti-DNA antibodies in comparison with drug-induced lupus, while in the latter there will be higher titers of anti-histone antibodies. Renal and central nervous system involvement is more common in ATIL than in drug-induced lupus. ATIL is a self-limiting condition that usually disappears upon withdrawal of the anti-TNF- α therapy, but it may occasionally require treatment with corticosteroids or immunosuppressants.

Methotrexate has been used successfully to treat patients with coexistent SLE and psoriasis and is emerging as one of the best therapeutic options in this setting.









اسم الفرع / الجمالية

جامعة الأزهر
مستشفى الحسين الجامعي
قسم الباثولوجيا الإكلينيكية

Patient Name : السيدة / أسماء السيد قطب
Referred by : قسم / الروماتيزم و التأهيل
Registration Date : 2015-10-10
Lab Number : 22726



Age : 25 Y

Complete Blood Count

Test	Result	Unit	Normal Range	
Hemogram				
Hemoglobin Level	8.5	g/dl	(12	- 16)
Hematocrit	26.7	%	(36	- 46)
Red Cell Count	3.5	millions/ul	(3.8	- 4.8)
M.C.V.	77.4	fl	(78	- 96)
M.C.H.	24.3	pg	(26	- 32)
M.C.H.C.	31.8	g%	(30	- 35)
RDW	17.3	%	(11.5	- 14.5)
Total Leucocytic Count	4.6	$\times 10^3/\text{ul}$	(4	- 10)
	Relative		Absolute	
Neutrophils Band	1 %	(0 - 6)	46	/ul ³ (0 - 800)
Neutrophils Seg.	68 %	(40 - 75)	3128	/ul ³ (2000 - 8000)
Lymphocytes	29 %	(20 - 40)	1334	/ul ³ (1000 - 4000)
Monocytes	1 %	(2 - 10)	46	/ul ³ (200 - 1000)
Eosinophils	1 %	(1 - 6)	46	/ul ³ (100 - 600)
Basophils	0 %	(0 - 2)	0	/ul ³ (0 - 150)
Platelets Count	155	$\times 10^3/\text{ul}$	(150	- 400)

اسم القرع / الجمثيه

مدير الوحدة / د. عزة العنوي
طبيب الوحدة / د. ايمان ياسين

المختبر
al mokhtabar
مختبر مؤمنه كامل

Patient ID : 30115011637
Patient Name: الأستاذة / اسماء السيد قطب
Age / Sex : 24 Year / FEMALE
Referred By : Prof.Dr. -
Client Name : 2590

Registered : 30
Collected : 30
Authenticated : 30
Reported : 02

PARASITOLOGY REPORT

TEST NAME	RESULT	UNIT	BIOLO
Urine Analysis			
MACROSCOPIC EXAMINATION			
Colour	Yellow		
Aspect	Clear		
Volume	10.0	ml	
Reaction	5.0		4.7 - 7.
Specific Gravity	1020		1.005-
Nitrite	Nil		Not De
Albumin	Nil		
Sugar	Nil		Not De
Acetone	Nil		Not De
Bile Salts	Nil		Not De
Bile Pigments	Nil		Not De
Urobilinogen	Normal Trace		Norma
MICROSCOPIC EXAMINATION			
RBCs	0-1	/H.P.F	0 - 1
Pus Cells	2-4	/H.P.F.	0 - 1
Epithelial Cells	Few		
Casts	Nil		
Ova	Nil		
Crystals	Nil		
Mucus	Nil		
Yeast Cells	Nil		
Trichomonas vaginalis	Nil		Abse

A. Ad
Dr. Azza EL
Professor of
Faculty of medicine

اسم الفرع / الجنيه
مدير الوحدة / ا.د. عبد العزيز النقلي

المختبر
al mokhtabar
mosama kamal laboratories
مخبر مأملة كامل

Patient ID : 30115011637
Patient Name: الأستاذة / اسماء السيد قطب
Age / Sex : 24 Year / FEMALE
Referred By : Prof.Dr. -
Client Name : 2590

Registered
Collected
Authenticated
Reported

CHEMISTRY REPORT

TEST NAME

RESULT

UNIT

B

Urine Chemistry Analysis

Protein / creatinine ratio
Urinary Protein
Urinary Creatinine
Protein/ creatinine ratio

39.32

141

279

mg/dL

mg/dL

mg/ gm
creatinine

قسم الباثولوجيا الاكلينيكية
وحدة المناعة

طبيب
أزهري
بن الجامعي

Name : أحمد السيد
Date : 2.10.1914
Referred : رصاص

- Anticardiolipin : (Ig M) : 15
(Normal less than

(Ig G) : 23.0
(Normal less than

- Bilharzial Antibodies : /
(Diagnostic titre

- Human Growth Hormon (HGH) : /

- Basal / ng /

- After Insulin / ng /

(Normal less

ليس مجلس الإدارة

اسم الفرع / الجمالية

عانة الأزهر
تشفى الحسين الجامعي
م الباثولوجيا الإكلينيكية

Patient Name : السيدة/ اسماء السيد قطب
Referred by : قسم/ الروماتيزم و التأهيل
Registration Date : 2015-09-29
Lab Number : 21198



Age : 25 Y

Microbiology

Test	Result	Unit	Normal Range
CRP (Latex)	-ve	mg/L	(0 - 5

قسم الباثولوجي الإكلينيكية
وحدة المناعة

كلية الطب
جامعة الأزهر
مستشفى الحسين الجامعي

Name: محمد السيد Date: 20/10/2010

REPORT

Anti: anti-mumps assay by Elisa

AMA : 128 u/ml

Positive 760 u/ml

DNA : 498 u/ml

Positive 7375 u/ml

C3 73.1 mg/dl

N. 91-156 mg/dl

C4 12.5 mg/dl

N 20-50 mg/dl

[Aliaa Omar El-hady](#) Drs. [Bassel El-Zorkany](#) [Howaida Elsayed](#)
[Mansour](#) [Basant Esawy](#) [Mohammed Hassan](#) [Rageh M.](#)
[Elsayed Sherry Kamel](#)

[Amg Amg](#)

الحمد لله الذي عافانا مما ابتلى به كثيرا غيرنا وفضلنا على كثير ممن خلق تفضيلا

[Aliaa Omar El-hady](#)

اللهم امين

[Basant Esawy](#) Very nice and interesting case with wonderful analysis dr Aliaa Omar El-hady
Thanks for sharing

You are right MTX is the best option for her
Also if needed HCQ can be used as I have psoriatic patients misdiagnosed as RA and given HCQ without psoriasis exacerbation or transformation inspite what we know (but this is from experience point of view)

[Aliaa Omar El-hady](#)

[Howaida Elsayed Mansour](#) If she has lupus nephritis cyclic pulse endoxan and soluomedrol will be the golden solution dear.dr [Basant Esawy](#)

[Howaida Elsayed Mansour](#) We have a patient like her, she is lupus and has typical skin psoriasis. ..the ttt in this case is induction of remission acc to the individual patients clinical condition eg..if she has active urinary sediments or protein / createnin ratio 500 mg renal biopsy should be done and ttt of lupus nephritis by cyclic pulse endoxan and soluomedrol will have the priority, but if she has No lupus nephritis or cerebritis, the best is to induce remission by pulse soluomedrol 1gm daily for 3 days followed by Methotrexate 18 mg /week as MTX will be the golden solution for both the skin lesions and the arthritis - but after induction of remission by pulse soluomedrol and in all conditions she should of course take hydroquine 200 1x2 + 20 - 30 mg oral steroids nice case dear dr.[Aliaa Omar El-hady](#) and dr. [Mohamed Magdy](#)

[Aliaa Omar El-hady](#) thanks Dr. [Howaida Elsayed Mansour](#) [Amg Amg](#) Dear prof [Howaida Elsayed Mansour](#) pulse steroids in this case given for what exactly?

[Howaida Elsayed Mansour](#) Amg Amg for induction of remission of very active lupus with autoimmune haemolytic anemia and very high ESR with complement consumption even without nephritis. ..

[Like](#) · [Reply](#) · [2](#) · [December 9, 2015 at 2:35am](#)

[Mohamed Magdy](#) It is my case

[Aliaa Omar El-hady](#)

وكنت عايزة اعرف lupus nephritis انا فعلا عرضتها علشان من التحاليل فيها لازم [Mohamed Magdy](#) يتعمل لها ايه لو متابعة لسه معاك يا د. مجدى renal biopsy تعمل لها

[Howaida Elsayed Mansour](#) Very interesting case dr [Mohamed Magdy](#) she should take pulse soluomedrol even with MTX bec she has aggressive lupus with coombs positive autoimmune haemolytic anemia and very high acute phase reactants...

[Aliaa Omar El-hady](#)

فعلا حالة جميلة وشدتني جدا واسلوب عرضها ممتاز سلمت يداك يا د. [Mohamed Magdy](#) مجدى

[Mohamed Magdy](#)

واتحسننت كثير high dose steroid , + Methotrexate بالحالة أخذت proteinuria جدا ، واختفت

[Aliaa Omar El-hady](#)

[Mohamed Magdy](#)

that the combination of SLE and psoriasis is very rare but reported كان الهدف من عرض هذه الحالة

[Rageh M. Elsayed](#) Nice case and good jop thanks

alot [Mohamed Magdy](#) [Aliaa Omar El-hady](#)

[Howaida Elsayed Mansour](#) Dear dr. [Mohamed Magdy](#) pls keep an eye on her Blood pressure , regular urine analysis and protein / createnin ratio any abnormalities renal biopsy is highly indicated

2- if she was having lupus nephritis on presentation she will

flare any time later bec MTX is not a good choice in lupus nephritis even if the proteinuria disappears temporarily. ..

[Mohamed Magdy](#) We prepared the pt now for renal biopsy , and follow up the case is our job

[Aliaa Omar El-hady](#) [Mohamed Magdy](#) ياريت تعرفنا بالجديد اول باول يا دكتورنا

[Mohamed Magdy](#)

إن شاء الله

[Gigi Elzohirey](#) Thanks D/Mohamed Magdy for this nice case & nice presentation

[Mohammed Hassan](#) nice case dear all colleages. nice work using MTX in ttt both conditions but after induction of remission of lupus by puse steroid

[Sherry Kamel](#) it is very interesting case dr.[Mohamed Magdy](#)...., your management by pulse steroid and then MXT, is very good. but I think your patients has sever aggressive skin psoriasis which will not respond accurately to MXT alone . On other hand the associated SLE will made the drugs choice is very challengeSo , we have to review our literature about TNF in SLE , IS It contraindicated or ineffective???

[Howaida Elsayed Mansour](#) Anti TNF alpha is contraindicated in lupus. ..

[Mohamed Magdy](#) Read again my discussion about the case and ttt with anti TNF is controversial in SLE , the anti TNF may induuce SLE , one of the drug , thanks a lot Dr.[Sherry Kamel](#)

[Sherry Kamel](#) ok , I read it againwe stil have the same Q , if this svere skin psoriasis is not respond to MXT, what is the next step???

[Mohamed Magdy](#) We raise the dose of MTX (full dose) and the skin manifestations improved

[Sherry Kamel](#)

grin emoticon -ياريت الحالات كلها نسنجيب للعلاج كده

[Mohamed Magdy](#)

رجالة الأزهر بقى ، أيديهم على الجرح تطيب على طوووول

Sherry Kamel

د. محمد ..انا قصدي انك ممكن في مرحله تلاقي الصدفية غير مستجيبه وبالتالي
.....يعني تديه وانت خايف controversy..رغم انه anti=TNFتضطر انك تدي ال

Howaida Elsayed Mansour Dr. Sherry It is not important the
state of skin disease any time lupus is a priority...

Sherry Kamel dear dr. **Howaida**. I try to find Magic solution
for both diseases (SLE& Psoriasis)

Marwa Abdo

لكن لا تؤثر على drug induced lupus ممكن تسبب anti TNF صحيح ان
لذا اذا استدعت الحاله اعطاءها فلن يكون منها ضرر باذن الله genuine SLE

Mohamed Magdy

، نظريا كلامك صح لكن واقعا معرفش ، احنا **Dr. Sherry Kamel**فاهم قصدك
، لكن للأسف both diseaseنشوف العلاج البيولوجي اللي ممكن يشتغل علي
there's a big difference in pathogenesis of both diseases

Case 26

Rehab Ali

December 9, 2015

Dear professors and colleagues,

A fifteen years old female child was presented to our clinic complaining of right ankle pain and swelling of 1 week duration

.
The condition started at the age of 2 years with history of recurrent fever lasting for 3 days every month and recurrent chest infection at the age of 5 years old the patient mother noticed deformities in fingers with no history of arthritis at the age of 10 years old there was history of swelling both calf muscles and ankle she sought medical advice and was diagnosed as rheumatic fever according to ASOT as her father said and received penicillin ..2 years ago she had hoarseness of voice and rash over UL at sites of joints in the form petichae there was no history of arthritis only generalized pain and fatigue On examination tenderness at right ankle joint, deformities of both hands boutonniere deformities, hallux valgus deformity and flat foot...

Investigation

Esr 16 mm/hr

CRP less than 6 mg/dl

RF positive

ASOT less than 200

Serum uric acid 4.5

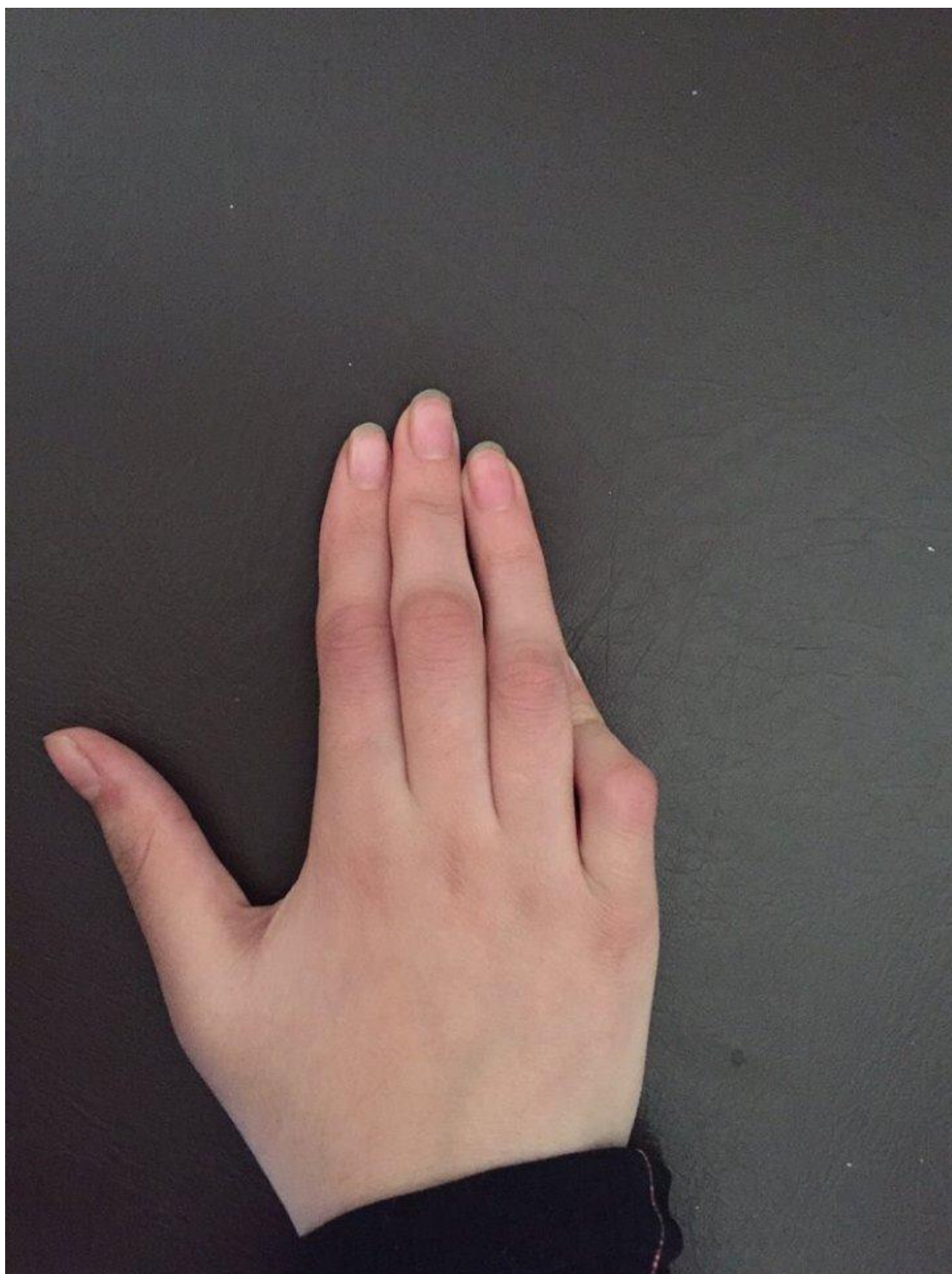
Musculoskeletal ultrasound was done revealing synovial hypertrophy and erosion at wrist

No abnormality detected at MCP, PIP joints and tendons

X Ray both hands, pelvis/abdominal US and anti ccp were

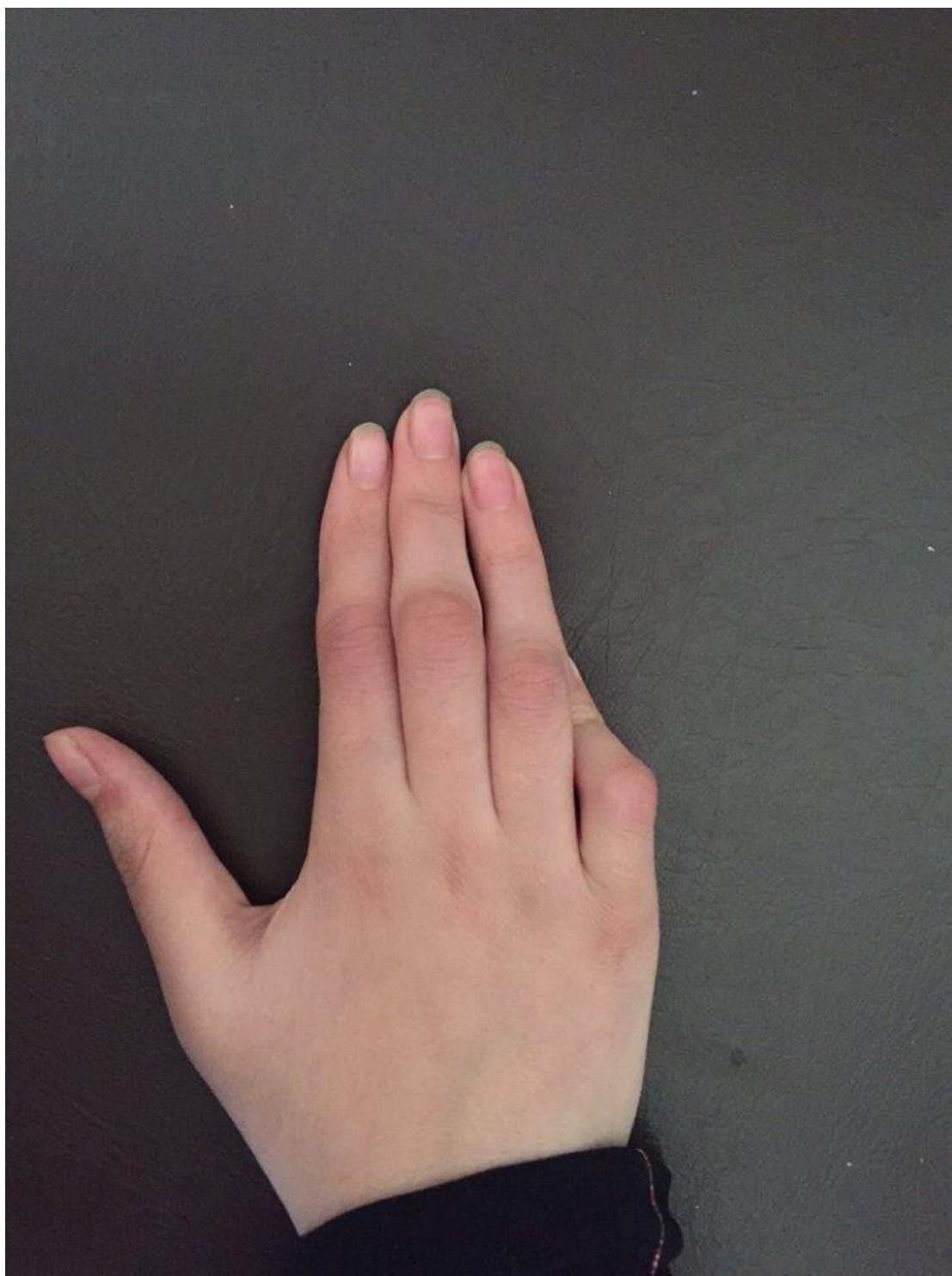
..recommended for confirmation of JIA

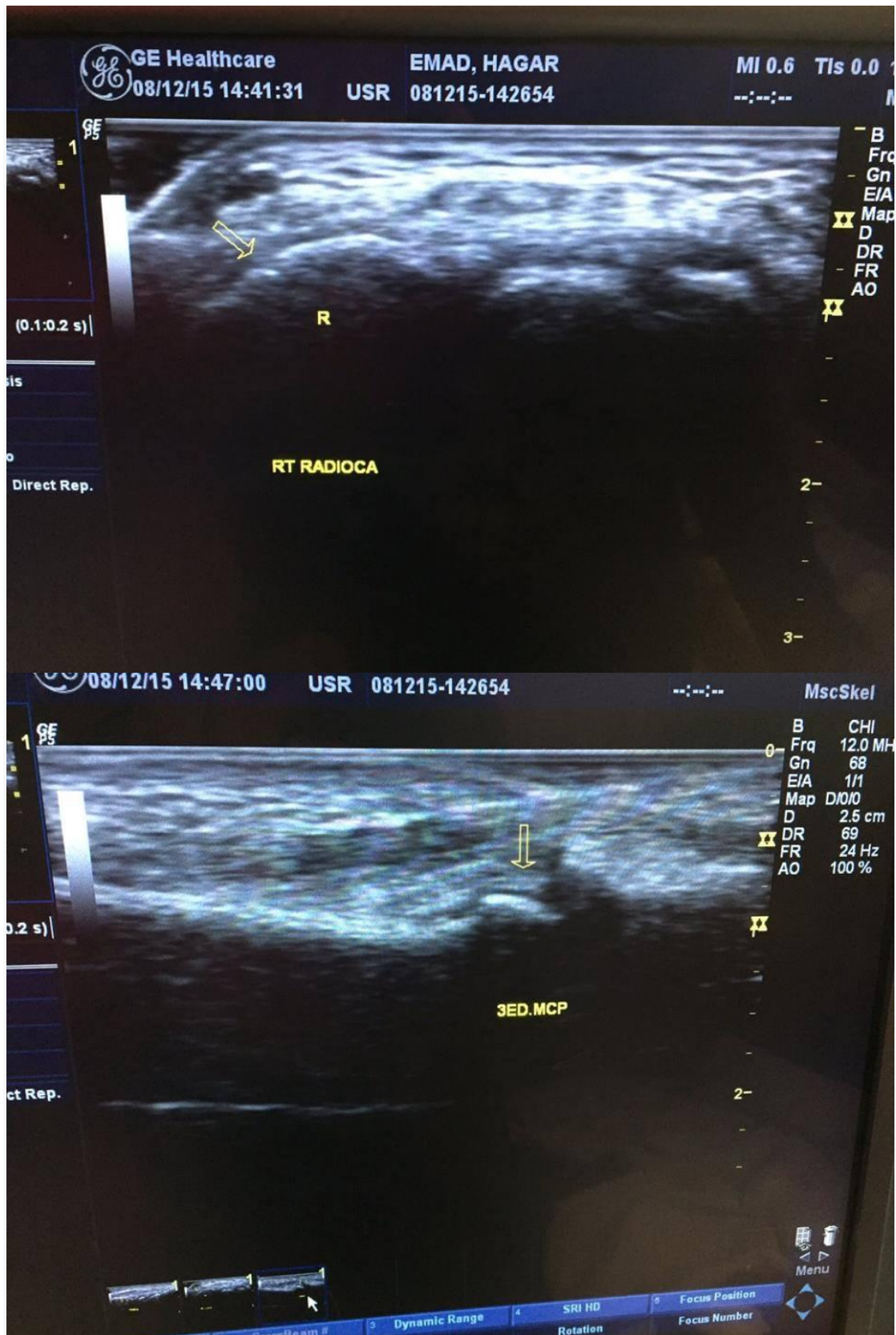
Any suggestions??













[Aliaa Omar El-hady](#) [Howaida Elsayed Mansour Rageh M.](#)
[Elsayed Sherry Kamel Basant Esawy Tamer](#)
[Elfarahaty Mohammed Hassan Ahmed Fahmy](#)
[Aliaa Omar El-hady](#) [Mona Mansour](#) [Reem Hamdy Hanan](#)
[Saleh](#)

[Mona Mansour](#) Please ask for ANA, CBC and urine analysis, liver and renal functions. Of course it is not rheumatic fever as there is persistent erosive arthritis. The diagnosis of JIA is most likely the diagnosis.

[Ahmed Fahmy](#) Nice case

Please check for periodic syndrome

Also check ANA

Calf swelling and fever ??

[Rehab Ali](#) Systemic JRA is associated with fever

[Aliaa Omar El-hady](#)

ابتدیتی معاها ای علاجات؟؟

Rehab Ali about Calf swelling I do not know the cause they did Doppler and was free as they said

Rehab Ali No Dr Aliaa we did not start management she is on penicillin are these details enough to start methotrexate or it is better to wait for investigations

Aliaa Omar El-hady I think this is Systemic JRA... need to start MTX... there is erosions

Rehab Ali But there is no lymphadenopathy or salmon pink rash also are deformities common with systemic type?? We thought it may be polyarticular arthropathy RF positive type

Aliaa Omar El-hady **Amal El Ganzoury**

Reem Hamdy Check for anti ccp ANA periodic fever syndromes

Reem Hamdy Start MTX immediately

Youssy Said F

Basant Esawy Of course this is not rheumatic fever

As we have synovial hypertrophy , erosions and deforming arthritis so we have systemic poly articular inflammatory joint disease with a lot of differential

So we need ANA, CCP, s ferritin, C3c4, CBC, repeat ESR and CRP LFT , KFT,urine analysis and occult blood in stool chest xray

Eye exam

Be sure that the pt did not receive steroid in private clinic as it is common malpractice

JIA , systemic onset still DD also as one of the complication deforming arthritis , not all pt have lymphadenopathy , 90 % have rash during the attack of fever and may not be noticed

You need 5 criteria at least 2 major

Periodic syndromes not erosive

Recent ACR 2015 documented presence of erosions in SLE pt by ultrasound

Fever , ankle arthritis chest xray to r/ o sarcoid also

Swollen calf from upper part ?? Rupture backers cyst as DVT ruled out

If lower one third of the leg so check for achilis tendinitis

Salha Monuer Is periodic fever cause deformity?

Rageh M. Elsayed 1- +ve polyarticular JIA (age less than 3 years)with predilection to wrists mcp and pip RF must be +ve twice 3 months apart 2- systemic onset usually sero_+ve form 3- we need ACCP ,ferretin and ANA to differentiate SLE slit lamp eye test other routine labs 4- we must start MTX As patient has erosions 5-anti TNF may be used if MTX failed to control

Mohammed Hassan nice case i think it's JCA but rule out juv. lupus and sarcoidosis so complete immunological profile and start MTX 0.3:0.8 mg/kg/wk

Tamer Elfarahaty 1) Sero +ve RF poly erosive JIA further work up to rule out SLE & still's(anti CCP; full CBC;Ferttin ; KFT ;LFT;ANA by INF , C3 ;4; slit lamp). 2) erosive arthritis need to start MTX . 3) bilateral swelling of calf muscles are not common with DVT or backer cyst rupture (mostly unilateral) . Doppler rule DVT. Examine Tendoachilles. Any proximal weakness ? May be pseudo hypertrophy of associated hypothyroidism especially with hoarseness of voice (Thyroid profile). 4) in adult RA ;persistent hoarseness of voice may be due to Carotid artery affection & RA nodule.

Rehab Ali Thanks a lot for your valuable suggestions

Omer Mala Ahmed Thanks Dr Rehab Ali for sharing this case :

Simply I think in addition to the above pictures we need also to see the plain films , because if the condition is sero +ve JIA with such gross deformities it should be associated with frank erosions & joint distribution on plain films .

If such deformities are not associated with joint distribution then we should think about Jaccoud arthropathy of SLE especially if the deformities are reversible, because even in SLE as Dr Basant Esawy said we may find erosions on US but they are simple & fine & usually could not be seen on plain film unlike those seen in JIA .

I think it's not ARF absolutely .

With normal acute phase reactants & poly articular joint involvement We should think about metabolic diseases or some specific syndromes or joint hyper mobility behind these manifestations rather than inflammatory arthritis (especially i see

these tall fingers are not normal & hope we see the face pictures) .

From the history also not goes with sJIA .

Great regards

Keep us on next investigations & the Final result

Howaida Elsayed Mansour What about recurrent attacks of chest infections, fever and hoarseness of voice and what is the relation between all this and her arthritis ...

Howaida Elsayed Mansour Dear all, dear dr. Rehab Ali there is a very important starting point in this case that is the recurrent attacks of chest infections and fever every month starting early in childhood this girl likely have congenital disease called cystic fibrosis (CF) and there are 3 types of arthritis that might associate CF :

1- large LL joint migratory arthritis as a form of ReA that recure with the flare of chest infection

2- CF may induce frank sero +ve polyarticular rheumatoid like arthritis with erosions and deformities like in this case and she should be ttt like RA by DMARDs + concomitant ttt of the chest infection.

3-CF may induce pulmonary hypertrophic osteoarthropathy. Plain x ray chest , pulmonary functions and high resolution CT chest are very important , pls read

<http://www.cfmedicine.com/htmldocs/cftext/arthritis.htm>

Ahmed Fahmy I'm totally agree with you prof.Howaida

This patient show something different

Calf swelling

Recurrent infection

Periodic fever

All these sign should be considered and investigated well before diagnosis is made

However she may be finally diagnosed as JIA,but we should exclude other befot

Howaida Elsayed

Mansour <http://journals.plos.org/plosone/article...>

Voice Disorder in Cystic Fibrosis Patients

Cystic fibrosis is a common autosomal recessive disorder with drastic respiratory symptoms, including shortness of breath and chronic cough. While most of cystic fibrosis treatment is dedicated to mitigating the effects of respiratory dysfunction, the potential effects of this disease on vocal param...

JOURNALS.PLOS.ORG

Howaida Elsayed

Mansour <http://journals.plos.org/plosone/article...>

Voice Disorder in Cystic Fibrosis Patients

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JOURNALS.PLOS.ORG

Howaida Elsayed Mansour What is cystic fibrosis ?
<http://www.cysticfibrosis.org.uk/.../what-is-cystic-fibrosis>



What is cystic fibrosis - Cystic Fibrosis Trust

Information on what is cystic fibrosis

CYSTICFIBROSIS.ORG.UK

Rehab Ali **Amal El Ganzoury**

Rehab Ali Sorry I forgot to mention that the patient had deformity in both little fingers in flexion since birth can this go with arthrogryposis

Aliaa Omar El-hady No , not arthrogryposis

Aliaa Omar El-hady please do thyroid function test & CPK... there is cases of hypothyroidism associated with pseudohypertrophy of calf muscles know as Hoffman's syndrome

Aliaa Omar El-

hady<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3125002/>



A young lady with swelling and stiffness of calf muscles

Hypothyroidism causes a variety of changes in the body. Though uncommon, hypothyroidism can present as myopathy. Hoffman's syndrome is a specific, rare form of hypothyroid myopathy, which causes proximal weakness and pseudohypertrophy of muscles.

NCBI.NLM.NIH.GOV

Tamer Elfarahaty We suggest hypothyroidism in a case of calf swelling only if associated with proximal muscle weakness. Hoffman's in adult named Kohler's disease (very rare syndrome with myopathy; muscles pseudohypertrophy especially calf and delayed dental & motor development) occurs in long standing moderate to severe hypothyroidism (cretinism); more in male and often with normal EMG. Pseudohypertrophy disappears after thyroid replacement therapy.

Case 27

Aliaa Omar El-hady

November 27, 2015

Case study (مقدمة من صديقة لى بقسم روماتيزم أسيوط)-

----- Personal history

Salah Ali Mohammed , male patient 38 years old, from
married, has one daughter aged 14 years old, he is farmer with
no special habits.

Complaint and its duration:

Itchy skin lesions in both hands and feet of 30 years duration.
Polyarthralgia of 4 years duration.

History of present illness

The condition has started since 30 years by appearance of
bullous eruptions on both hands and feet recurrent every 2-3
weeks, lasting for 1-2 days, disappearing spontaneously leaving
reddish desquamated pruritic thickened skin.

Since 18 years, the patient has complained of erythematous,
pruritic, papular skin lesions over the back, groin, chest, elbow
& extensors of forearm, exacerbated by exposure to sun on the
sun exposed areas, minor trauma or contact to heavy objects,
lasting for 1-2 days, relieved spontaneously and recurrent every
7-10 days.

The patient claims that both types of lesions develop burning
sensation on exposure to sun to the extent that he does not
tolerate his clothes.

The patient sought medical advice and received treatment but he
was not aware of the treatment he received and was not
compliant.

Recently, the patient was diagnosed for the resistant skin lesions
on the hands and feet as palmoplantar keratodermatitis for

which he received medical treatment in the form of tablets and topicals (Acitretin tbs, mondo cream, diprosalic ointment).

- Since 2011, the patient started to complain of intermittent polyarthralgia in Rt wrist, Rt shoulder, bilateral knees, ankles and hips, lasting for one week resolving spontaneously recurrent every month but in the last three months, the pain has become persistent in the wrist and knees without signs of inflammation.

- Two years later, the patient has complained of inflammatory low back pain with morning stiffness more than one hour worsened by rest and improved by activity.

- The patient gives +ve hx of bilateral eye redness, and burning sensation since 3 years.

The pt sought medical advice and received topical treatment but he did not improve due to lack of compliance.

Recently, he was diagnosed as conjunctivitis.

- The patient has hx since 3 years of intermittent attacks of colicky abdominal pain, distention sometimes associated with diarrhea, tenismus and mucus, lasting for 1-2 day, resolving spontaneously and recurring on average every 10 days.

The patient also gives hx of occasional spots of blood in the stool (occurred three times).

(The patient is known recently to have varicocle.)

The patient reports no fever or weight loss.

The patient sought medical advice and received treatment but no improvement in his condition due to lack of compliance.

There is a history of recurrent attacks of painless oral ulcers recurrent every 1-2 months, lasting for 3-5 days since 2 years. The ulcers resolve spontaneously.

The patient has developed since 2003 loin pain and burning micturation for which he sought medical advice that revealed the presence of renal stones and he receives medications till now.

Patient suffers from easy fatigability & malaise.

No history suggestive of CNS, cardiac or respiratory system affection.

Past history

History of operative intervention in the Rt eye in 2003

History of operative intervention for piles in 2003

History of parasitic infestation 18 years ago.

Family history

His sister was reported to have history of similar but milder form of skin lesion.

The patient was admitted in our department in the past three weeks.

Summary

- Palmoplantar keratodermatitis of 30 years duration with family history in the 1st degree relative.
 - Polyarthralgia & inflammatory back pain
 - Recurrent attack of colicky abdominal pain, diarrhea, mucous, tenismus & occasional bleeding spots
 - Bilateral conjunctivitis
 - Recurrent painless oral ulcers
 - Renal stone & hx suggestive of urithritis
-

Examination

General examination:

- The patient is alert and comfortable in bed with average body built.
- There is no pallor, no jaundice, no cyanosis .
- There is bilateral Conjunctivitis

Vital signs:

- Blood pressure:130/90 mmHg.
- Pulse: 80 beat/min.
- Respiratory rate: 16 cycle/min.
- Temperature: 37°C.

Systemic examination:

Head and neck examination: clinically free.
Chest and heart examination: clinically free.
Abdominal examination: clinically free
Neurological examination : clinically free
Lymph node ex: CF.

Skin examination :

palmoplantar keratodermatitis lesion , Scratching marks on both
ant surface of legs and show brittle& dry skin.

Mskuloskeletal examination

► Upper & lower limb

Inspection :

No redness or swelling of any joints

No wasting of muscles

palpation:

No hotness, swelling or tenderness of any joint

ROM:

Full ROM of all joint except

Rt elbow show → flexion deformity of 10 °

Bilateral knee show mild effusion.

Limitation of ext. rotation of Lt hip

Normal muscle tone & muscle power

Normal reflexes

Neck & Back examination

Inspection : scratch mark in upper Rt part of the back

Palpation :

There is spasm of paravertebral ms.

-Ve tenderness on the spine or SIJ.

ROM :

Neck : no limitation of movement

Back : no limitation of movement

Normal Chest expansion.

Special tests

Faber test +ve on Rt side

–ve modified Schober test.

Provisional diagnosis

Male pt 38 years old, keratodermatitis, oligoarthritis, conjunctivitis, inflammatory back pain, with hx suggestive of UT & GIT infection. The patient is most probably Reactive Arthritis.

Lab Investigation

ESR (5/20)

WBC 4.96 K/UL

RBC 4.99 M/UL

HGB 14.9 g/dl

PLT 288 K/UL

GLU: 5.3 mmol/L

Uric acid : 4.5 mg/dL

KFT: Normal

LFT :

AST 60 U/L

ALT : 64

LDH 278 U/L (80- 235)

Urine volume 4360 ml/24 hr (750- 1500)

Urine protein 436 mg/24 hr (up to 150)

Creatinin clearance 114.9

RF -ve

ANA –ve

Abdominal US show stone in Rt kidney

Urine analysis : ureate + , Ca. oxalates ++ & bacteria +

Stool analysis bacteria +

Current treatment

The patient is prescribed for:

-Methotrexate S.C.12.5mg/week

- Meloxicam tab twice/ day

Final diagnosis

Male pt 38 years old, spondylitis, asymmetrical SIJ , Dactylitis, enthesitis, oligoarthritis with urithritis , enteritis ,conjunctivitis & painless oral ulcer , pt has reactive arthritis

Differential diagnosis

1- psoriatic arthritis

Skin lesions in the 1st degree relative

Psoriasiform skin lesions

Conjunctivitis

Radiological findings of Enthesitis (Greater trochanter, iliac crest, symphysis pubis)

Sacroiliitis

Spondylitis

2- Enteropathic arthritis

Spondylitis and sacroiliitis

Intestinal symptoms : abdominal pain, diarrhoea, cramping, and the passage of blood or mucus per rectum.

Radiological findings of Enthesitis (Greater trochanter, iliac crest, symphysis pubis)

upper GI endoscopy needed FOR confirmation or exclusion

3- Ankylosing spondylitis

Inflammatory back pain

Radiological findings of Enthesitis (Greater trochanter, iliac crest, symphysis pubis)

Sacroiliitis

Spondylitis

4- undifferentiated PA

5- Behcet

Oral ulcers

6- SLE

Oral ulcers & erythema on sun exposed area





[Aliaa Omar El-hady](#) [Mai Rabie](#) [Mai Amin](#) [Sara Saeed](#) [Safaa Sayed](#)
[Sara Saeed](#) Thanks dr. Aliaa

[Mai Rabie](#)

حلوه قوي بس طلعت اي

[Aliaa Omar El-hady](#) Reactive Arthritis.

[Mai Rabie](#)

اي skin lesion طيب reactive يعني لو

[Aliaa Omar El-hady](#) reactive arthritis (triad of arthritis+conjunctivitis+urethritis)

Reactive Arthritis

- **'Reiter's Syndrome'** (classic triad)
 - 1) **Urethritis/Cervicitis**
 - 2) **Conjunctivitis**
 - 3) **Arthritis**

'Can't See, Can't Pee, Can't Climb a Tree.'

- Generally associated with **HLA-B27** on serology
- Post-venereal type is particularly associated with ***Chlamydia trachomatis*** infections

Safaa Sayed Very interesting dr Aliaa

Wesam Goda Nice case , but i think ENDOSCOPY is recommended as he gave history of recurrent attack of colicky abdominal pain, diarrhea, mucous, tenismus & occasional bleeding spots , as if IBD is confirmed the line of ttt could be changed from MTX to SSZ, aslo Meloxicam may exacerbate IBD so Cox-2 selective NSAIDs may be safer

[Like](#) · [Reply](#) · [8](#) · [November 28, 2015 at 1:24pm](#)

Howaida Elsayed Mansour Very very interesting dr. Aliaa omer El- hady

Marwa Abo Almauty Very nice case dr [Aliaa Omar El-hady](#), but reactive arthritis mostly disease duration 3 to 5 months and remit completely and some case persistent for 6 to 12 months but our patient here has long history of arthritis 4 years and GIT infection for 3 years

Aliaa Omar El-hady

ده تشخيص الدكتوراة اللى متابعة الحالة و د. هويدا ود. عمر فعلا اضافوا تحليل جديد للحالة وعلاجها وان شاء الله سيؤخذ فى الاعتبار

Omer Mala Ahmed Nice case dr [Aliaa Omar El-hady](#) & thanks alot for sharing this case.

Regarding the ttt i think SSZ is superior over the MTX as it useful for both bowel inflammation & arthritis .

I think this case is candidate for biological agent (infleximab or adalimumab) as you know these two biologicals are effective in spondyloarthropathies when there is associated collitis .

Howaida Elsayed Mansour dr. [Aliaa Omar El-hady](#) IgG4 disease is a DD... the link between allergy and autoimmunity. ..he has mild elevation of liver enzymes (autoimmune hepatitis)

the recurrent attacks of diarrhea abdominal pains and tenismus may be due to chronic autoimmune pancreatitis very famous in this syndrome with bullous pemphigoid in the palm usually associated with neuropathy / neuritis

Omer Mala Ahmed Please Whats IGD4 dear prof **Howaida Elsayed Mansour**?

Howaida Elsayed

Mansour <http://www.uptodate.com/.../overview-of-igg4-related-disease>

Link to IgG 4 disease dr **Omer Mala Ahmed**

lterers

Overview of IgG4-related disease

Immunoglobulin G4-related disease (IgG4-RD) is an increasingly recognized immune-mediated condition...

UPTODATE.COM

Howaida Elsayed Mansour We just need to check for total serum IgG4 level in this man dear dr **Aliaa Omar El-hady** if increased this will confirms the diagnosis bec. the long allergic history in this man is very obvious.. and this is not the case in reactive arthritis ..

Aliaa Omar El-hady

Omer Mala Ahmed و د **Howaida Elsayed Mansour** جزا كما الله خير ا د .. والدكتورة اللي متابعة الحالة متابعة لتحليل حضراتكم ليها وان شاء الله تعمل التحليل المطلوب وتشوف امكانية اعطاء بيولوجى وان شاء الله توافينا بالجديد

Gehad Adel Pt has 2ndry infilterity so we cant give him SSZ he has oligoathenoazospermia

Aliaa Omar El-hady

Howaida Elsayed Mansour التحليل ده بيتعمل فين يا د. هويدا

Howaida Elsayed Mansour

مثلا في معامل مستشفى عين dear dr. Aliaa في اي معمل في القاهرة bec this patients has signs and symptoms cant be explained by reactive arthritis

Aliaa Omar El-hady Update in this case: The patient do colonoscopy and it is free... then it is not IBD

Case 28

Rageh M. Elsayed

December 5, 2015 · Jubail, Saudi Arabia

Male pt, aged 31 ys complaining from neck and LT TMJ pain 3 months ago with dizziness and occipital headache examination revealed severe neck muscle spasm tenderness over sub occipital area and occiput, decrease ROM especially LT rotation and bending neurologically free no eye ,sinus or tooth problem for diagnosis and management





Howaida Elsayed Mansour We need full history dr. **Rageh M. Elsayed** male with this severe neck pain and stiffness and muscle spasm for 3 months with TMJ affection , x ray shows lost cervical lordosis, his spine looks osteoporotic due to long lasting inflammatory process, we need to exclude RA ...cervical spine is very commonly affected in RA, is there any other joints affection ?? ESR ? CRP ? RF and anti - CCP it is very important to exclude RA

Yara Tawfik What is his occupation ??

Rageh M. Elsayed Accountant

Rageh M. Elsayed Thanks prof **Howaida Elsayed Mansour** actually no joint affection no signs of RA or other rheumatological diseases

Abdallah El-Sayed Allam I will do US to examine the cervical spine specially sub-occipital muscles and the sub occipital nerve,,,i may take look to the 3rd occipital nerve too....according to the pathology i will do injection into the muscle + hydro-dissection of the nerve if entrapped

Rageh M. Elsayed Yes there is very severe spasm tenderness to the limit the patient cannot rotate to the LT 0 degree LT rotation

Howaida Elsayed Mansour What about ESR CRP ,RF ??

Rageh M. Elsayed Actually not done our prof

Yara Tawfik According to my little experience , sometimes certain jobs can cause resistant regional pain ,, e.g. pathologist , lab technicians complain of long standing neck pain .. here the accountant may remain long time flexing his neck ,, can this be a clue ?? Can the ms strain enter a viscous cycle ??

Rageh M. Elsayed Yes it is pure mechanical problem

Rageh M. Elsayed We know that cervical rotation takes place at Atlantoaxial joint plz check the AP view. Of x Ray and see the position of dens of C2

Omer Mala Ahmed Fracture of C2 dense process

Rageh M. Elsayed No the dens is tilted to LT lateral mass of atlas no fracture dear **Omer Mala Ahmed**



Youssy Said Dens is tilted to the left side....

Rageh M. Elsayed Yes the dens is tilted to LT lateral mass of atlas see normal centralized dens in open mouth view



Rageh M. Elsayed Here our abnormality shifted dens to the LT and c2-7 rotated to right



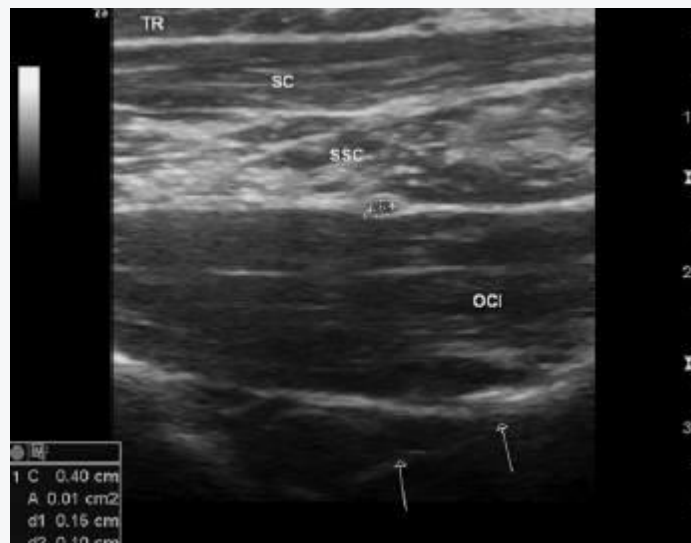
Yara Tawfik Can this tilt be the cause of the strain ?? And can this be caused by fault positions ??

Aliaa Omar El-hady I think he must do MRI to know the cause of shift may be space occupying lesion..also need to request for dental surgeon.. Do ESR,CRP,.. If all free and just mechanical, if it needs chairopractic treatment????

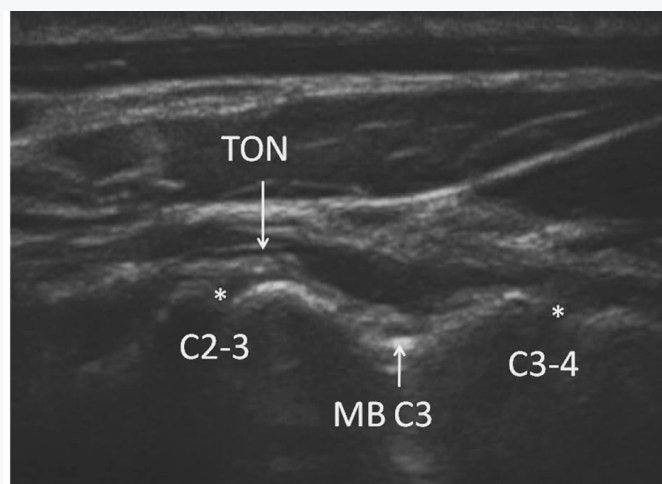
Abdallah El-Sayed Allam



Abdallah El-Sayed Allam



Abdallah El-Sayed Allam 3rd ocn



Howaida Elsayed Mansour

keep on انت خلاص بقيت استاذ سونار وده كويس جدا

Abdallah El-Sayed Allam

انا له فى طور Howaida Elsayed Mansour ربنا يعز حضرتك بروفييسور
التعلم

GeHad Ramadan Maziad Is there an atlanto-axial subluxation ??

Rageh M. Elsayed No subluxation only shift of dens laterally it is Atlantoaxial dysfunction

Aliaa Omar El-hady What about your treatment plan

Sir?? **Rageh M. Elsayed**

Rageh M. Elsayed 1- instruction for good ergonomics 2- work up to release suboccipital muscles and scm and trapizus with diffrent available modalities 3- mobilization of lt AAJ to right 4- mobilization of rt c2-7 to lt. i will post isa the x ray after 5 mobilixation to compare

Aliaa Omar El-hady Please can you put how to do every manipulation because many of doctors dont know how to do even by videos and photos..plz and thanks a lot

Aliaa Omar El-hady D. **Rageh M. Elsayed**

Rageh M. Elsayed

https://www.youtube.com/watch?v=SOs_fQ3hp6g&feature=you



Atlanto/Occipital Distraction & Mobilization

Catherine M. Doll, DMT, MOMT, PT, in representing Ola Grimsby Institute, shows us a cervical technique:

Atlanto/Occipital Distraction & Mobilization

YOUTUBE.COM

Rageh M. Elsayed <https://youtu.be/3QGgbdz4u1I>



C1 on C2 mob and testing

YOUTUBE.COM

4M



C3-7 z-joint and u-joint mobilizations

Disclaimer: These videos are intended for the use by students enrolled in HESC 405 and 406 at the University of Delaware to use as study aids for their writt...

YOUTUBE.COM

Aliaa Omar El-hady

Rageh M. Elsayed جزاك الله خيرا ونفع بعلمك

..

Aliaa Omar El-hady Need to know the updates Dr **Rageh M. Elsayed**

Rageh M. Elsayed good am dr aliaa thanks god the patient improvment of pain tenderness and dizness by 50 % after 2 adjustment he may need another 2 adjustment and will x ray him and update you thanks

Aliaa Omar El-hady thank you for your effort

Case study :

A 59-year-old male presented with elevated creatinine of 6 months duration, discovered at the time of a routine physical.

He complained of recent onset of fatigue and severe muscle pains in thighs. The thigh pain that had been present for many years was worse in the last 6 months.

He would occasionally get “sinus headaches” and had experienced multiple attacks of sinusitis in the past.

He denied a history of fever, weight loss, skin rashes, joint pains and visual complaints.

Review of systems was otherwise negative.

He was extensively evaluated elsewhere and a presumptive diagnosis of vasculitis was made.

Cyclophosphamide and prednisone therapy was advised and he sought a second opinion at our hospital.

Past medical history was complex and significant for the following:

(1) Pituitary insufficiency: This was diagnosed 14 years prior to presentation. Evaluation revealed a peri-pituitary mass and thickened pituitary stalk. Biopsy of the stalk showed dense fibrous tissue with lymphocytic infiltrate.

(2) Sinusitis status post two sinus surgeries. Maxillary sinus biopsy at surgery had shown polypoid respiratory mucosa with chronic inflammation, numerous eosinophils, and non-necrotizing granulomatous inflammation. Definitive vasculitis and areas of necrosis were not seen.

(3) Coronary artery disease.

(4) Asthma.

(5) Chronic peripheral eosinophilia ranging from 8.7 to 17.6% (normal 0–7%).

Physical examination:

Vitals: Height: 184.0 cm. Weight: 95.40 kg. BMI: 28.178 kg/m

2 . Temperature: 36.6 °C. Pulse Rate: 77/min, regular, Blood Pressure: 121/60 mmHg, (Right arm) standing.

General: Well developed, well nourished, in no acute distress. Eyes showed mild ptosis of left lid (present since birth) with normal fundus and visual field examination. A small shotty node was palpated in the inguinal region with no other lymphadenopathy.

ENT, thyroid, skin, lung, heart, abdomen, joint, neurologic, and spine examinations were normal.

Laboratory values:

-Hemoglobin, white blood cell count and platelet count were normal.

-Differential count showed eosinophilia (eosinophils 1.36×10^9 /L, normal $0.05\text{--}0.50 \times 10^9$ /L) and a peripheral blood smear showed rouleaux formation.

-ESR and CRP were elevated at 104 mm/at 1 h (normal 0–22 mm/1 h) and 3.7 mg/dL (normal < 0.8 mg/dL) respectively.

-Serum creatinine was 2.6 mg/dL (normal 0.8–1.3 mg/dL, patient's baseline 1.2 mg/dL) and BUN 41 mg/dL (normal 8–24 mg/dL).

-Urinalysis showed protein/osmolality ratio of 0.54 (normal < 0.12), but was otherwise normal.

24-h urinary protein was 964 mg (normal 0–150 mg in 24 h).

-Other blood chemistries namely liver biochemistries, uric acid, serum electrolytes and serum glucose were unremarkable.

-Hepatitis serologies were negative for HBsAg and HCV.

-Serum protein electrophoresis show polyclonal hypergammaglobulinemia, immuno fixation and urine protein electrophoresis were normal.

-Autoantibodies, namely RF, ANA, dsDNA and ANCA were negative.

-Renal ultrasound showed bilateral cortical thinning and possible focal scarring lower pole right kidney. The right kidney measured 10.9 cm, and left kidney 12.4 cm.

-Unenhanced CT chest and abdomen showed paraspinal masses along the thoracic spine at about the level of T7 through T10. The appearance of masses was felt to be suspicious for lymphoma. Soft tissue thickening adjacent to the left lateral border of the descending thoracic aorta, abdominal aorta level of the mesenteric and renal artery origins, and above the aortic bifurcation was noted. Diffuse pancreatic atrophy and uniform wall thickening of the distal stomach and gastric antrum were seen.

Although the findings were nonspecific, a possibility of gastric lymphoma was suggested.

Differential Diagnosis

The patient presented with:

- renal failure of recent onset,
- paraspinal soft tissue masses,
- aortic thickening and
- a past medical history of pituitary insufficiency, sinusitis, lung disease (asthma), suggestive of a multisystem disease process.

1. Vasculitides :

Vasculitic processes like granulomatosis with polyangiitis (GPA, formerly Wegener's) can present with pituitary involvement, sinusitis, and renal insufficiency.

Kidney involvement typically presents with GN, RBCs and casts are usually seen in urine that were absent in this case. Histopathology of kidney shows pauci-immune, segmental necrotizing crescentic GN and biopsy from other organs shows necrotizing granulomatous inflammation.

Tumor like masses have been reported in GPA and are seen most commonly in breast or kidney.

A positive PR3 and c-ANCA is seen in most patients with multisystem GPA whereas this patient had negative tests.

Polyarteritis nodosa (PAN) can cause renal insufficiency with normal urinary sediment and negative ANCA serology.

PAN is typically associated with hepatitis B infection which was absent in this patient and would not explain other organ involvement (pituitary, sinusitis and paraspinal masses).

Peripheral eosinophilia, sinusitis and history of asthma can be seen in Churg –Strauss vasculitis. Lung abnormalities include non-cavitary nodules, pleural effusion or infiltrates.

Mononeuritis multiplex is the most common neurologic involvement and pituitary disease is rare. Biopsy shows necrotizing vasculitis with eosinophilia.

Aortic thickening can be seen in large vessel vasculitis like temporal arteritis or Takayasu's disease; however, patient's clinical scenario was not consistent with large vessel disease.

2. Granulomatous Disorders :

Sarcoidosis can present with granulomatous hypophysitis.

Lung involvement manifest as bilateral hilar adenopathy and/or interstitial

lung disease which were not seen in his case. Kidney involvement may include nephrocalcinosis or rarely granulomatous lesions. Aortic thickening is exceedingly rare and there were no articular or cutaneous manifestations of sarcoid.

3. Hematologic diseases :

Lymphoma as suggested in multiple imaging studies needs to be considered in the differential. Infiltration from lymphomatous processes

can present with renal insufficiency, paraspinal masses, and peripheral

eosinophilia. However, the patient's distant pituitary disease would remain unexplained by lymphoma. Histiocytic disorders can involve the pituitary; however, other characteristics were not noted. Hypereosinophilic syndromes can present with

multiorgan manifestations; however, the organs involved were not typical for this condition.

4. Miscellaneous :

Retroperitoneal fibrosis (RPF) can present with aortic thickening and renal insufficiency secondary to ureteral obstruction. Although aortic thickening was noted the fibrotic changes of RPF were not seen. RPF can be associated with other fibroinflammatory processes like sclerosing mesenteritis and IgG4 related disease (IgG4RD).

The pancreatic atrophy noted in abdomen raises the possibility of autoimmune pancreatitis (AIP), the pancreatic manifestation of

IgG4-RD; however, this is a nonspecific finding and can be seen in those with a history of pancreatic disease or advanced age.

In addition to pancreatic disease, IgG4-RD can involve pituitary, lungs, kidney, aorta, salivary glands, biliary tree and eye. The diagnosis is made on the basis of typical organ involvement supported by serologic, radiographic and histopathologic findings.

Lastly the present episode of renal insufficiency may be completely independent of previous medical problems and other renal diseases like chronic tubulointerstitial nephritis would need to be excluded. Renal biopsy would be a helpful investigation.

Working diagnosis :

Atypical GPA or a low grade lymphoma.

Workup :

The following additional tests were obtained.

Angiotensin converting enzyme (A.C.E) 31 U/L (Normal, 7–46 U/L),

total immunoglobulin 1,390 mg/dL (Normal 600–1,500

mg/dL),
IgG1 473 mg/dL (Normal 490–1,140 mg/dL),
IgG2 599 mg/dL (Normal 150–640 mg/dL),
IgG3 49.0 mg/dL (Normal 20–110 mg/dL),
and IgG4 833 mg/dL (Normal 8.0–140.0 mg/dL).

Imaging

-
1. MRI chest and abdomen: In addition to findings noted on CT scan MRI showed diffuse pancreatic atrophy with slight dilatation and irregularity of the main pancreatic duct. There was abnormal perfusion to both kidneys with bilateral cortical infarcts.
 2. MRA thoracic and abdominal aorta: There was asymmetric wall thickening in the aortic arch, more prominent along the left side. Circumferential wall thickening of the descending thoracic aorta extending from the level of the pulmonary arteries to the level of the diaphragm, abdominal aorta at the level of the celiac artery origin and extending to the level of the bifurcation with involvement of the origin and proximal left renal artery was noted.

Biopsy:

Biopsy of the paraspinal mass was obtained and previously obtained biopsies were reviewed.

1. Renal Biopsy: Glomeruli were obsolescent with features of hypertensive nephrosclerosis. There were no features to suggest vasculitis. Immuno fluorescent and electron microscopy showed no evidence of immune complex deposits.
2. Fine needle aspiration and biopsy of paraspinal mass: Chronic lymphoplasmacytic infiltrate and storiform fibrosis . Immunoperoxidase studies showed a mixed population of T cells (CD3 positive) and B cells (CD20 positive). The plasma cells were polyclonal for kappa and lambda

immunoglobulin light chains.

Immunohistochemical stain for IgG4, showed abundant IgG4-positive

staining plasma cells

What Is Your Diagnosis and Why?

A unifying diagnosis for this patient's clinical scenario, including

- peripheral eosinophilia,
 - aortitis,
 - paraspinal pseudotumors, and
 - pancreatic atrophy,
- could be explained by IgG4-RD.

Although membranous nephropathy and tubulointerstitial nephritis

can be seen in IgG4-RD, the renal biopsy did not suggest either of these etiologies.

Rather, the renal insufficiency was felt to be secondary to extension of the periaortic process along the renal blood vessels causing segments of ischemia and/or infarction.

In the setting of serum IgG4 elevation greater than two times the upper limit and supportive histopathology and immunohistochemistry, the diagnosis of IgG4-RD is confirmed.

The patient was treated with steroids and had reduction in serum creatinine

levels, IgG4 levels that subsequently normalized and size of the paraspinal

masses. He relapsed following discontinuation of steroids, but responded to re-induction with steroids and addition of mycophenolate mofetil. He has remained in clinical & serologic remission without disease relapse or new organ involvement for last 7 years.

Final Diagnosis:

IgG4 related disease.

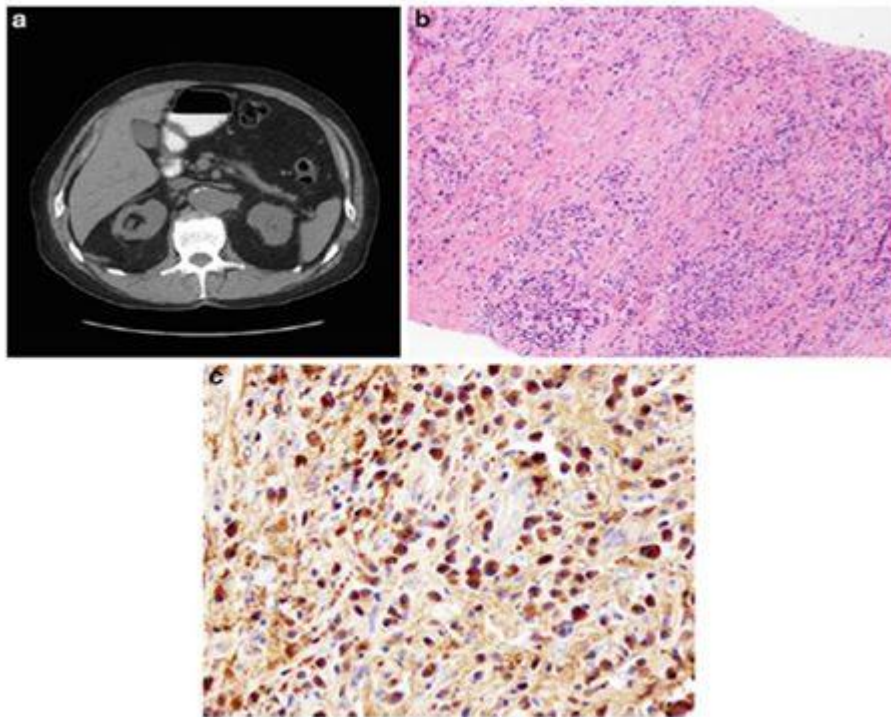


Fig. 5.1 (a) CT chest (non-contrast) showing thickening of aorta. (b) Biopsy of right paraspinal soft tissue mass showing lymphoplasmacytic infiltrate and classic storiform fibrosis. (c) Abundant IgG4+ staining plasma cells on immunohistochemical stain (power $\times 40$)

Case 30:
Omer Mala Ahmed

December 15, 2015 · Ranya, Iraq

🔄 65 years old woman today presented to me complaining of bilateral knee pain with minimal swelling , previously had history of bilateral knee pain but in the last two months she found exacerbation of her knee symptoms with elevation of ESR (her daughter is medical staff).

The knees are mildly swollen , no joint problem in other joints, No fever ,no history of other significant symptoms.

Just had past medical history of Asthma & now she is ok & not using any drug for asthma.

☐ INVESTIGATIONS:

▬ CBC : Unremarkable

▬ ESR : 95

▬ CRP : Strongly positive (48)

▬ GUE : pus Cell +

▬ RF : -ve

▬ RFT : Normal

▬ LFT:Normal

▬ S.Uric Cid : 3.5

▬ Abdominal US: Normal

▬ CXR : Normal

▬ Knee X-Rays: Evidence of OA changes

▬ LSS & Pelvis Xray : I found multilevel degenerative disc diseases & if iam not wrong calcification of dorasal spine intervertebral discs .

▬ SF analysis : I tried to do it but the aspiration was traumatic & blood mixed with SF so i couldn't do SF WBC analysis but what can only do is checking for SF viscosity grossly which was markedly reduced.

☐ Diagnosis:

I diagnosed the case as CPPD.

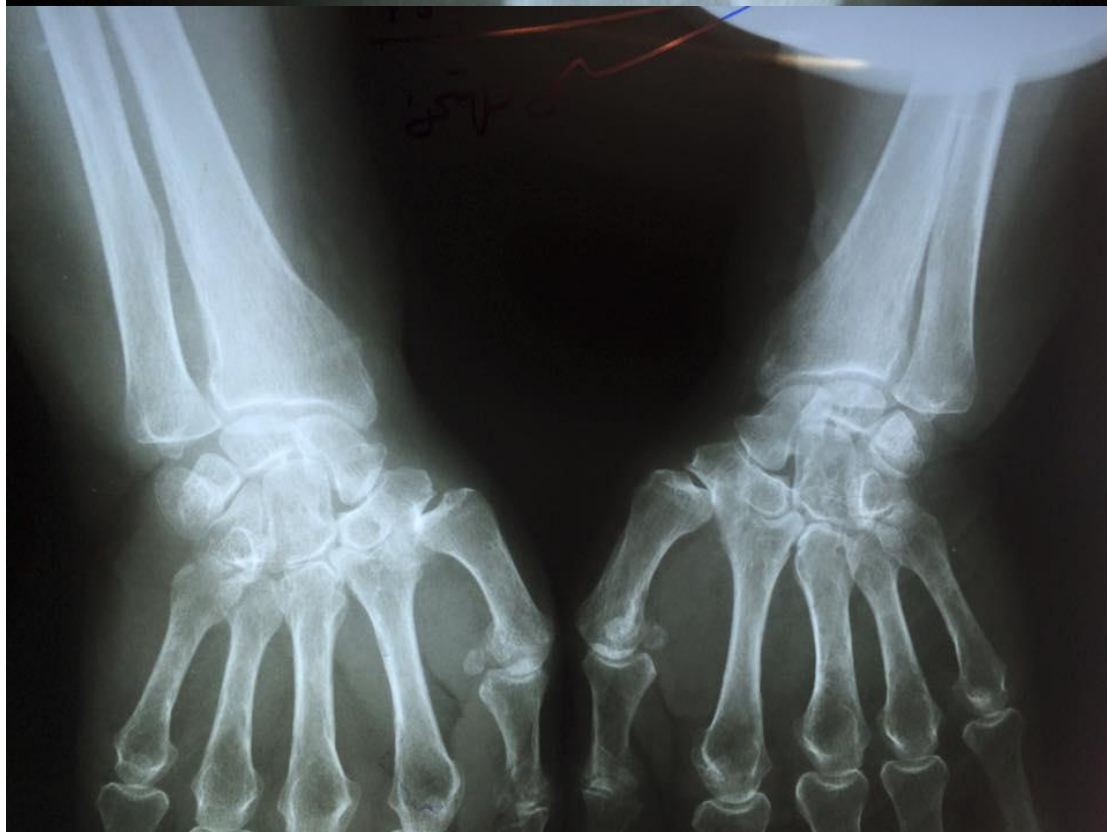
☐ Treatmen:

▬ Diprofose 2cc IM injection (she refused intra articular injections)

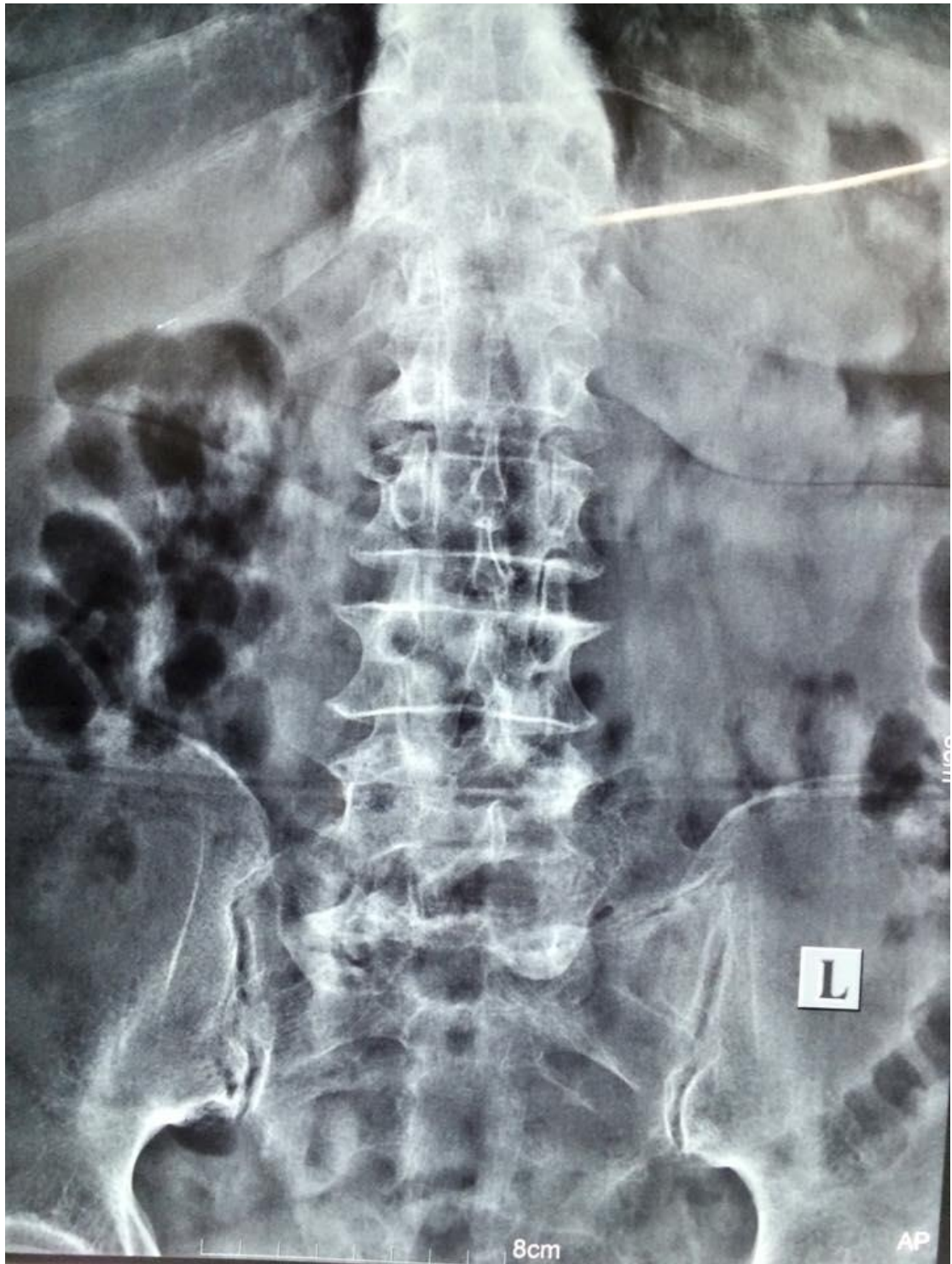
▬ Colchicine 0.5mg *2

- Panadol joint 1*3
- Suprax 400mg * 1 for her mild UTI.
- Your Opinions regarding the diagnosis & ttt ?

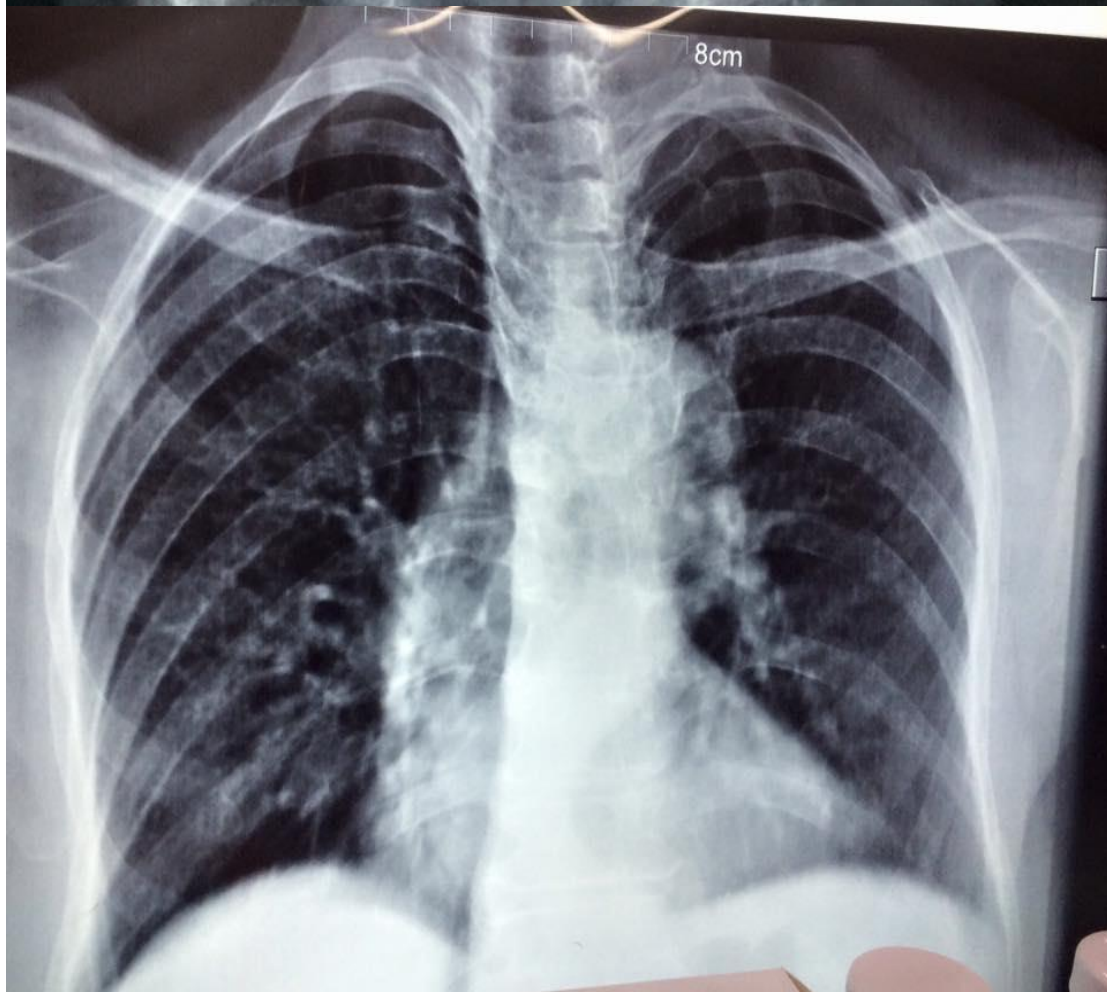
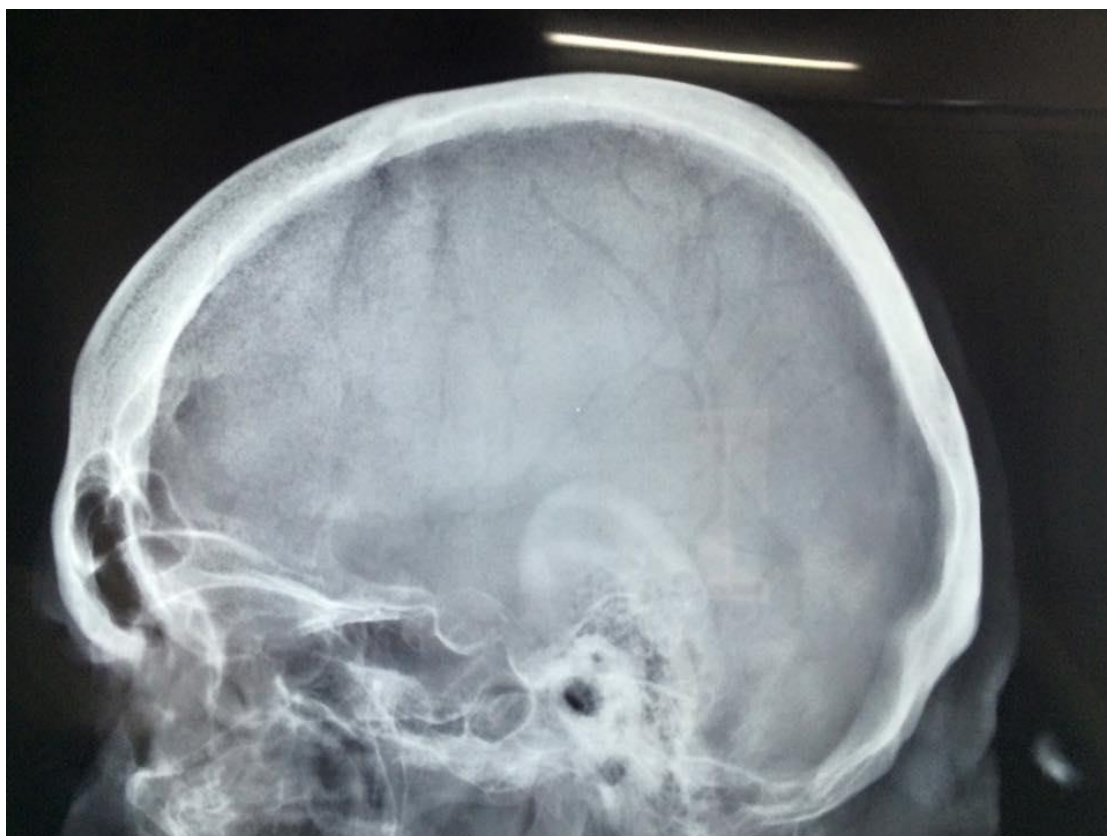












Omer Mala Ahmed Dear profs & Doctors
Howaida Elsayed Mansour, Tamer Elfarahaty , Rageh M.
Elsayed, Basant Esawy , Sherry Kamel , Mohammed
Hassan, Mohamed Ismail, Mona Mansour, Amal El Ganzoury.....

Mohammed Hassan nice case dear dr omer ... i think so it's
CPPD but if there is any enthesopathy or eye sympt to exclude
re arth

Omer Mala Ahmed No Enthesitis or Eye problems dear
Dr Mohammed Hassan, thanks for your Comment

Sherry Kamel It is unusual for both ESR and CRP to be high in
CPPD

Sherry Kamel I am agree with you ,the most probably
diagnosis is CPPD , although this high crp and ESR

أم البراء رفيدة Is there cruched vertebrea?

Mona Mansour Nice case dr Omer and good management but I
wonder why didn't you inject the joint during the procedure of
aspiration. I think that the amount of effusion was not enough to
aspirate. However the absence of systemic manifestations and
the therapeutic response to colichicine will confirm your
diagnosis

Omer Mala Ahmed Thanks for your comment dear Dr **Mona
Mansour** , as i said before the patient has bad idea about steroid
injection in to the joints & so she agreed to aspirate the fluid for
analysis but refused injection of steroid

Tamer Elfarahaty Acute knee arthritis in old age increase
possibility of acute CPPD. There is evidence of calcificatin in
knee xray.

synovial fluid analysis: WBC count ; differ. ;culture and
microscopic exam. Confirm diagnosis and roule out other
possibilites especially infection in old age with high ESR .
Septic arthritis some times involve more than one joints without
fever and minimal signs (repeatCBC) especially in old age.
MSUS (if available) is promising in CPPD . Need to roule out
associated diseases with CPPD: TSH; serum tansferrin ; IBC
(hemochromatosis) ; Alk ph ; PTH and serum Mg &Ph and

therapeutic history of antiresorptive drug induced pseudogout .
Add low dose of MTX if no response to colchicine

Omer Mala Ahmed Great thanks dear prof **Tamer Elfarahaty** for your informative comment, really I just see the OA changes in knees & I can't see calcification of cartilages (chondrocalcinosis).

In suspected cases of CPPD we usually arrange X-Ray of knees & Wrists, but we can't see clearly cartilage calcification in these two areas in this case ! Is it necessary also to arrange spinal X-Rays to find suggestive evidence of CPPD? Great

regards **Tamer Elfarahaty** I see faint calcification in lateral compartment of knee xray. Yes knee is most frequent site of CPPD . But it also in long ligament & disc of spine . Arrange spinal xray ; If no evidence of CPPD in knee & wrist or patient complain of neck & LBP . Crowded dens syndrome (CPPD behind odontoid) may a hidden cause of cervical pain with limited motion in old age (need to be excluded).

Rageh M. Elsayed good am dear drs 1- the pt has generalized oa 2- cppd is usually associated with in such old age(PSUEDO OA) 3- high phase reactant has big question mark and must be investigated in old age for multiple dd as dr Tamer Elfarahaty mentioned before 4-aspiration of synovial fluid and US are diagnostic

Basant Esawy Nice case dr **Omer Mala Ahmed**

I am totally agree with my respected colleagues

But what's make me worry in such case high ESR and CRP

You should also rule out malignancy in such age

أم البراء رفيدة old age + high ESR + crushed vertebrae , I suspect it is multiple myeloma also

Howaida Elsayed Mansour Excellent case presentation and management dr.Omer - as usual yes she is likely having pseudogout CPPC it is alone enough to cause high ESR but shouldn't be very high ...this is likely due to associated UTI . Start ttt of UTI by systemic ab for 10 days and repeat the ESR and CRP

Case 31

Abdelrahman Amer

December 20, 2015

62 years old woman complain of polyarthralgia ,pain in back in thoracic region and parathesia in hands , diagnosed as RA since 12 ys , no hx of joint swelling nor psoriatic lesion, -ve(oral ulcer , photosensitivity, alopecia)

□ Drug Hx: MTX 12.5mg/week
HCQ .vamid .NSAID.Bisphosphonates

□ Examination

Upper limb : reversible hand deformities like swan neck , ulnar deviation crepitus on movementsf PIPs , DIPs & wrist

Lower limb : both kness show mild effusion & creptius. both ankle arthritis. Foot show deformitis as flexion defomitiy of MTPs & overriding ot toes

Spine : tenderness over thoracic region

□ Hand Xray:

marked narrowing of PIPs , DIPs & intercarpal bones
subluxation of MCPs, ulnar deviation , Juxtaarticular osteopenia

□ Xray on lumbosacral :

marked spondylodegenerative changes, loss of normal kyphosis,
narrow IVD & wedge fracture

□ Lab inv :

RF +ve (32) , anti-CCP -ve, CRP -ve , ESR 1st hour 15,SGPT 61

anti -HCV ab +ve

normal (CBC ,RBS,S.creatinine, S.albumin, S.bilirubin)

□ US hand: PIPs &DIPs show

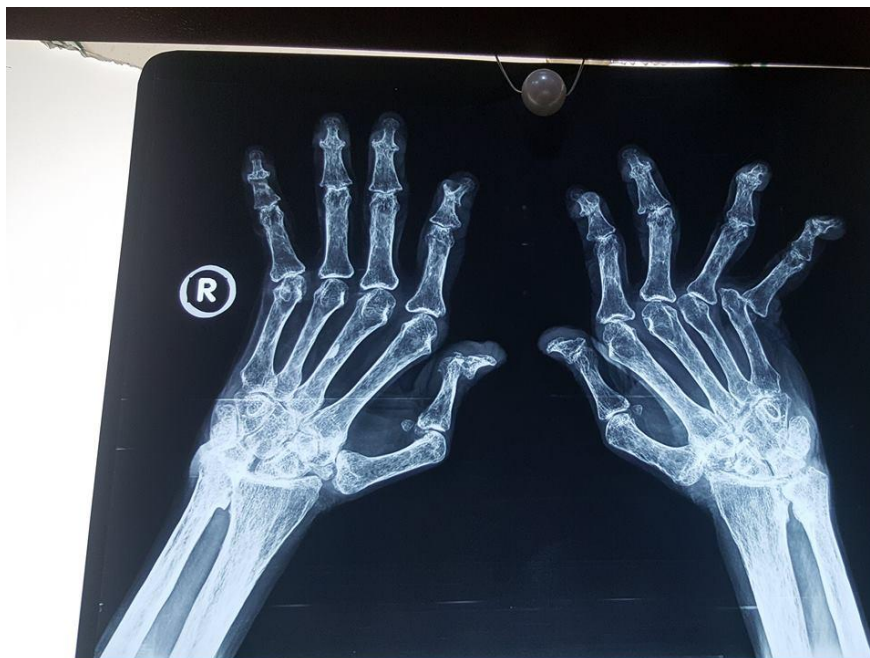
-grade 2 synovitis& multiple erosions

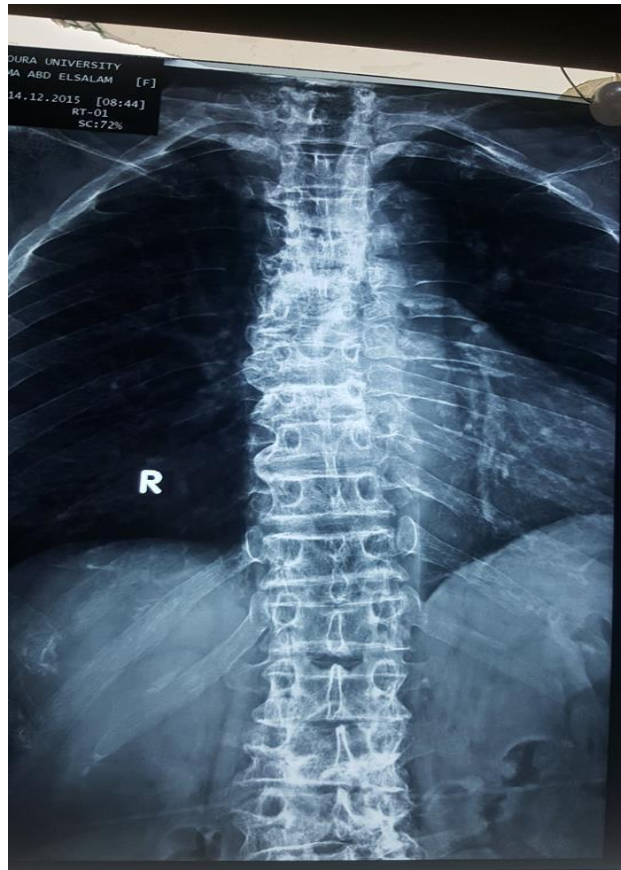
-no signs of crystal deposition

-conclusion:erosive polyarthritis sparing MCPs suggest
psoriatic arthropathy ?! (no hx psoriasis)

□ Treatment now on osteonate, Ca , vit.D, HCQ

what do you think about diagnosis?
RA? Erosive OA?













You, [Aliaa Omar El-hady](#), [Dina Moenes](#), [Amani Salama](#) and [8 others](#) like this.

[Abdelrahman Amer](#) Dear profs & Doctors [Howaida Elsayed](#) [Mansour Tamer Elfarahaty](#) [Rageh M. Elsayed](#) [Sherry Kamel Omer Mala Ahmed](#) [Aliaa Omar El-hady](#)

[Ahmed Seif El-Dein](#) Family history of Psoraisis!!!!

[Abdelrahman Amer](#) No

[Aliaa Omar El-hady](#) I think this is rheumatoid arthritis mutilans with DISH and osteoporosis (controlled with the previous DMARDs as normal ESR)

[Aliaa Omar El-hady](#) This is typical thoracic x_ray of DISH

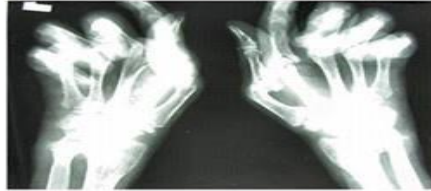
[Abdelrahman Amer](#) Thank you

[Abdelrahman Amer](#) These deformities can be corrected manually. What is RA mutilans ?

[Aliaa Omar El-hady](#) Arthritis mutilans as it called Opera glass or telescoping of digits

[Aliaa Omar El-hady](#)

Arthritis mutilans



Arthritis mutilans

Arthritis mutilans, is a rare **arthropathy** originally described as affecting the hands, feet, fingers, and/or toes, but refers in general to severe derangement of any joint.^[1] In the hands, it is also known as **opera glass hand** (*la main en lorgnette*), or **chronic absorptive arthritis**, first described in modern medical literature by Marie and Leri in 1913.^{[2][3]} Sometimes there is foot involvement in which toes shorten and on which painful calluses develop in a condition known as opera glass foot, or *pied en lorgnette*.^{[4][5]}

^ Etiology

Arthritis mutilans occurs mainly in patients with psoriatic arthritis and rarely advanced rheumatoid arthritis, but can occur independently.^{[4][5]}

9:55 43%

images.rheumatology.org

15 of 137



Keywords: [rheumatoid arthritis](#) [ra](#) [opera glass hand](#) [bony resorption](#)

talis

ption:	Rheumatoid Arthritis: Hand, "Opera Glass Hand" Dorsal view of the hand of someone with long-standing erosive rheumatoid arthritis shows the consequence of extensive bony resorption. Loss of skeletal elements resulted in marked foreshortening of the digits, culminating in "opera glass" deformity of the hand.
ite:	Hand
e:	Rheumatoid Arthritis
Type:	Photograph

[Aliaa Omar El-hady](#)

Radiography



Radiograph of the lumbosacral spine (lateral view) showing flowing anterior osteophytes indicative of diffuse idiopathic skeletal hyperostosis.

[View Media Gallery](#)



Radiograph of the thoracic spine (anteroposterior view) showing osteophytes on the right side only, a feature typical of diffuse idiopathic skeletal hyperostosis.

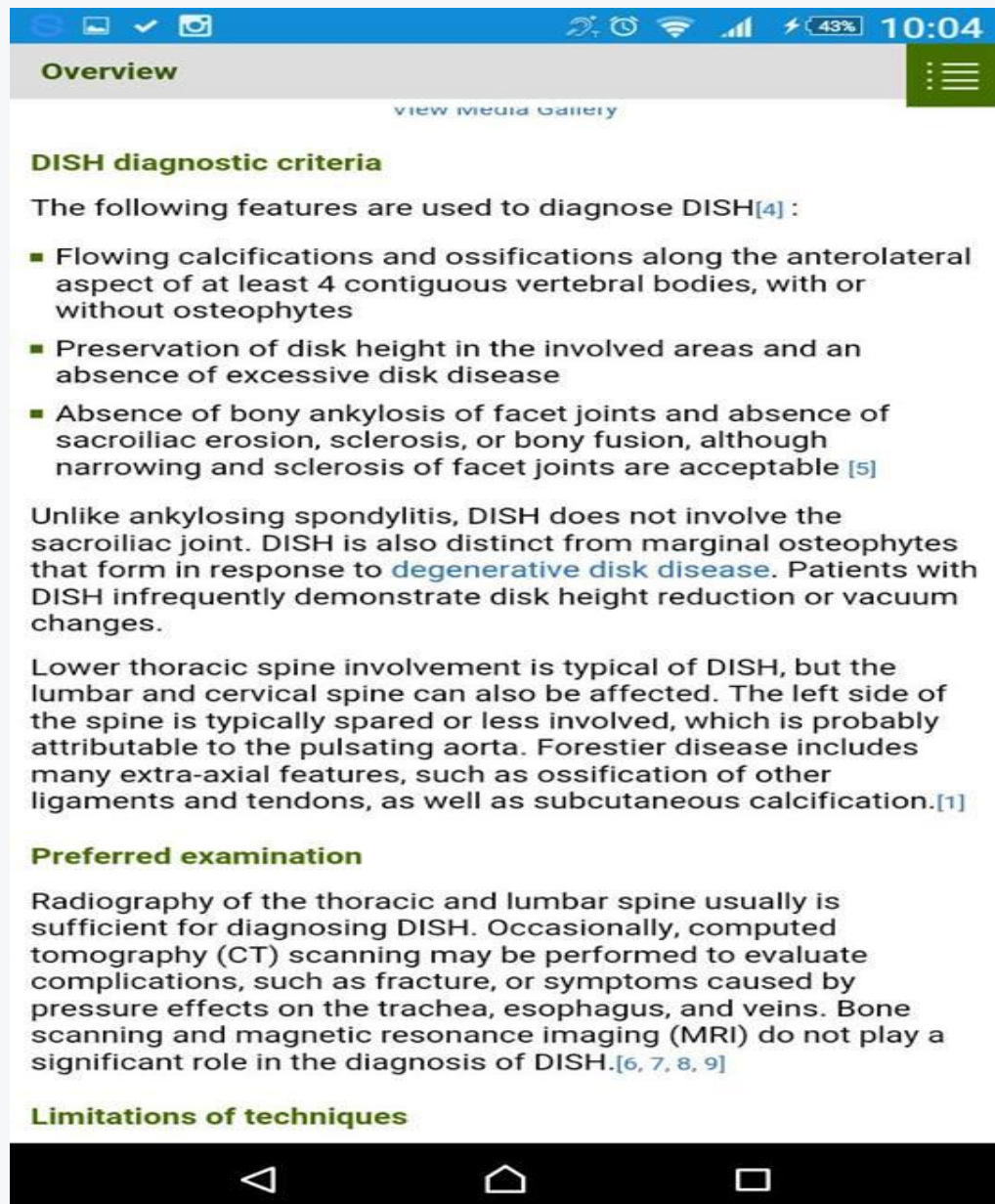
[View Media Gallery](#)

Degree of confidence

The hallmark of DISH is ossification occurring along the anterior aspect of the vertebral bodies but remaining separate from the



Aliaa Omar El-hady



Aliaa Omar El-hady

بتاعة الرجل بتتعدل وكمال الاشعة بتاعة الايد deformities لا يمكن تكون ال destruction... فيها

Abdelrahman Amer Hand deformities extension لما اعملها

D:بنفسي

Abdelrahman Amer

شكر ا د علياء

Abdelrahman Amer Foot deformities not reversible

Aliaa Omar El-hady Nice case Dr. **Abdelrahman Amer**
Rageh M. Elsayed Morning all thanks dr Amer for nice case I think the pt has EOA although RF+ve which is usually -ve in EOA but low titer in old age is accepted . Presentation has many DD as RA PsA gout and many endocrinal diseases as hypothyroidism hyperparathyroidism here we have 1- bil symmetrical affection 2- DIP and PIP severely affected 3- absence of skin affection of psoriasis 4- sclerosis osteopenia and central erosion of LT 5th and middle DIP gull wing characteristic of EOA but marginal in RA and periostitis in PsA and hanging edge in gout 5-ttt HCQ Colchicine and ca vit d and pispfosponate in resistant cases we may add 5 mg CS 6 - take care of kidney in those pt with the use of NSAIDS
Abdelrahman Amer Thank you

Basant Esawy I think this case of PSA (psoriatic sin psoriasis)and the use of MTX mask the skin lesions to appear The X-ray finding with Chch dip and sclerosis with mutilation plus tapering of the distal end in proximal phalanx and still broadening of the proximal end of distal phalanx in the index finger

Due to image quality there is ?? Acro osteolysis

Abdelrahman Amer Patient denies any hx of skin lesion like psoriasis

Basant Esawy There is 10% of psoriatic pt develop arthritis before skin lesions and your pt ttt with MTX which can mask any lesions to occur later in the course of the disease
What about nails no pitting?

Abdelrahman Amer No pitting in nail

Basant Esawy So as I said this is PSA masked by MTX and onset was PSA sin psoriasis

Nice for sharing such interesting case which can show the validity of radiograph and chronology of disease

[Aliaa Omar El-hady](#) [Howaida Elsayed Mansour](#) - [Amal El Ganzoury](#)- [Mona Mansour](#) - [Sherry Kamel](#) - [Tamer Elfarahaty](#) - [Omer Mala Ahmed](#)

[Omer Mala Ahmed](#) Dear Abdelrahman Amer thanks for this nice case sharing.

To me from the images :

1- affection of MCP joints which is very unlikely to be affected in EOA....[See More](#)

[Abdelrahman Amer](#) Thank you for such valuable information

[Tamer Elfarahaty](#) Dear Dr Abdelrahman Amer. Thanks for this nice case. 1) Mostly skin psoriatic lesion precede arthritis by years ;but arthritis may precede skin lesion sometimes in elderly . 2) Dermatologist consultation for hidden lesion in scalp ;umbilicus and anus . 3) Also low titre RF and even positive anti CCP can be seen in psoriatic Arthritis especially in old age. I see radiological sign suggestive PSA (Narrowing ; ankylosis of DIJ ((not commonly seen in RA)) ;Musrooming sign of left index ; subchondral bone erosion of DIJ of rt index ; whitening of DIJ of RT Ring finger ?? plus juxta articular osteopenia). Request xray of SIJ. Also xray of feet ? Enthesopathy?? May we see arthritis mutilans ?. Also there is high incidence of HCV in PSA. So i suggest this case of PSA.

[Abdelrahman Amer](#) Thank you

Omer Mala Ahmed

December 22, 2015 · Ranya, Iraq

40 years old female patient complaining of chronic bilateral Retro-Calcaneal pain , No evidence of inflammatory back pain or skin lesions or arthritis .

■O/E:

Bilateral Retrocalcaneal Tenderness with small local swelling.

No evidence of plantar fasciitis

Normal range of back movements & no evidence of Sacroiliac joint affection.

■INVESTIGATIONS :

ESR :23

CRP:strongly positive

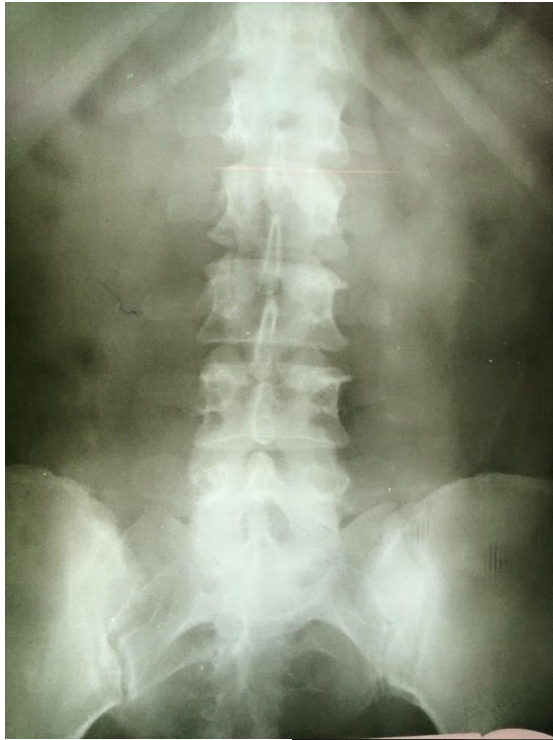
RF: -ve

GUE: Normal

■X-Rays : posted

□How we deal with this patient ?





Omer Mala Ahmed Dears profs & doctors
Howaida Elsayed Mansour , Tamer Elfarahaty , Rageh M.
Elsayed, Basant Esawy , Amal El Ganzoury, Aliaa Omar El-
hady.....

Aliaa Omar El-hady Is the small local swelling mean bursitis??

Aliaa Omar El-hady change the foot wear(Use of an open-backed shoe) - local steroid injection - progressive stretching exercise to tendoachillis- Microcurrent therapy

Omer Mala Ahmed No dear Dr **Aliaa Omar El-hady** there is no Bursitis , just like a bony swelling at the site of Retrocalcaneal bone spurs

Aliaa Omar El-hady change the foot wear(Use of an open-backed shoe) - local steroid injection - progressive stretching exercise to tendoachillis- Microcurrent therapy

Omer Mala Ahmed Dr **Aliaa Omar El-hady** she continuously use an open- Backed shoes , but i think with local steroid injection in this area there is risk of detachment of Achilles tendon insertion .

Amal El Ganzoury Hi dr Omer nice case the plain xray show sub condral sclerosis which should be further investigated by MRI. if there is signs of inflammation it is sero negative spondyloarthropathy with enthesitis and should be managed as though.

Also we have bilateral calcaneal spurs not clear if we have Doral spurs too.

if it is only retro calcaneal pain and no signs suggestive of sero negative , we can use laser better shock therapy if available plus stretching.

Rehab Ali May be Hugland deformity, with bursitis

Mohamed Zakaria most probably xanthomatous tendinitis please check for lipid profile (hypolipoproteinemia type 2a or type 2b)

Basant Esawy Hi everyday , totally agree with Dr Amal El Ganzoury SPA should be ruled out , as you have both calcaneal and retrocalcaneal spur with CRP positive

Is there Any family history of SPA, any history of preferring dysuria or uveitis?

Howaida Elsayed Mansour Dear all, dr. **Omer Mala**

Ahmed this lady likely have ReA -subtype of SPA (CRP strongly +ve) and this bilateral calcaneal spur is a result of ReA and increased bone formation with subcondral bone sclerosis - a

frequent sequelea of SPA..pls put her on Salazopyrine 500 mg 2 tab / 12 hours for 2 months + Vibramycin 100 g /12 hours for 10 days.. if pain persists local steroid injection is recommended - do HLAB27 and ask about any family history of psoriasis

Tamer Elfarahaty This Patient with Bilateral calcneal spur & bilateral insertional achiles tendnopathy so reactive arthritis is in top of possibilities until proven otherwise. Roule out genitourinary ; GIT infection & IBD. Slit lamp for subclinical uveitis . Treatment as prof Howida **Howaida Elsayed Mansour** mentioned .

Mona Mansour I agree with the management me tinned by our colleagues for SpA (reactive arthritis), and I would like to add that moderately high heal wedged shoe also open back would relieve some of the patient's pain during ambulation

Omer Mala Ahmed Thanks Dear profs Doctors for your valuable informative comments.

Howaida Elsayed Mansour, Amal El Ganzoury, Basant Esawy, Aliaa Omar El-hady, Tamer Elfarahaty, Mona Mansour, Mohamed Mohamed Zakaria,.....

Really Before 45 days this patient came to me & at that time I also thought about SpA behind this condition, she denied history of Recent UTI or personal & family history of psoriatic skin lesions or SpA .also had no history of eye pain or redness.

But still I thought about SpA behind her problem & putted her on SSZ & one Diprofose 2 cc IM injection & Nimuslide one tab 100mg / day (28 tabs) , 2 days ago returned to me & said i was good till the Nimuslide tab finished & after that the pain returned , So I told her that SSZ need time to work & i adviced her to continue on Nimuslide single tab 100mg daily in conjunction with SSZ till the SSZ start to work.

What's strange to me in this case is that ; with these great & fluffy plantar calcaneal Spurs she has no any pain in this area , just she complained of Retrocalcaneal area pain with maximum pain in the morning .

Can any body answer me :

1-Could ReA diagnosed without evidence of peripheral arthritis or Sacroiliatis?

2- where is the subchondral sclerosis? What's the significance of this sclerosis?

Great thanks Again

Basant Esawy Regarding the X-ray you are right fluffy spur goes with SPA and sclerosis is an indication of periostitis which is one of SPA feature

Yes you can diagnose SPA with out arthritis according to ASAS criteria

Enthrsitis is responsive to NSAIDs or loach injection if not then biological

Basant Esawy



ASAS Classification Criteria for Axial Spondyloarthritis (SpA)

In patients with ≥ 3 months back pain and age at onset < 45 years

Sacroiliitis on imaging*
plus
 ≥ 1 SpA feature

OR

HLA-B27
plus
 ≥ 2 other SpA features

*Sacroiliitis on imaging
• active (acute) inflammation on MRI highly suggestive of sacroiliitis associated with SpA
• definite radiographic sacroiliitis according to the modified New York criteria

SpA features:

- inflammatory back pain
- arthritis
- enthesitis (heel)
- uveitis
- dactylitis
- psoriasis
- Crohn's/colitis
- good response to NSAIDs
- family history for SpA
- HLA-B27
- elevated CRP

n=649 patients with back pain:

Overall
Sensitivity: 82.9%, Specificity: 84.4%
Imaging arm alone
Sensitivity: 66.2%, Specificity: 97.3%
Clinical arm alone
Sensitivity: 56.6%, Specificity: 83.3%



Rudwaleit M et al. Ann Rheum Dis 2009;68:777-783 (with permission)

ASAS Classification Criteria for Peripheral Spondyloarthritis (SpA)

Arthritis or enthesitis or dactylitis
plus

≥ 1 SpA feature

- uveitis
- psoriasis
- Crohn's/colitis
- preceding infection
- HLA-B27
- sacroiliitis on imaging

OR

≥ 2 other SpA features

- arthritis
- enthesitis
- dactylitis
- IBP (ever)
- family history for SpA

Peripheral arthritis: usually predominantly lower limbs and/or asymmetric arthritis
Enthesitis: clinically assessed
Dactylitis: clinically assessed

IBP: Inflammatory back pain

Sensitivity: 77.8%, Specificity: 82.2%; n=266



Rudwaleit M et al. Ann Rheum Dis 2011;70:25-31 (with permission)

MD exam _second part,commentary
Mansoura faculty of medicine



Mansoura Faculty of Medicine

Physical Medicine, Rehabilitation
and Rheumatology Department

MD Exam- Second Part
Commentary

Date: 12-12-2015

Total Mark: 60

Time allowed: 1.5 hours

Read the following scenarios and answer the next questions

Case (1)

(15 Marks)

A 48-year-old woman presents with complaints of diffuse muscle pain, weakness, and fatigue. She reports:

- Gradual onset over past 6 months
- Morning stiffness lasting 2 to 3 hours
- Difficulty with getting up out of a chair and combing her hair
- No problems with holding a brush or standing on her toes

Objective Findings

- Minimal muscle tenderness
- No joint tenderness or swelling
- Significant proximal muscle weakness in both upper and lower extremities
- No focal neurologic abnormalities

Questions

- 1- Discuss the differential diagnosis of this case
- 2- Indicate the most probable diagnosis and how to confirm it?
- 3- Determine the treatment options for this case

Case (2)

(15 Marks)

A 25-year-old woman with SLE has had difficulty with severe thrombocytopenia. Previous bone marrow biopsies showed increased numbers of megakaryocytes and no other abnormalities. Past therapy with high doses of corticosteroids has been successful in raising the platelet count to normal levels, but tapering to 20 mg/day has resulted in a progressive decline in platelet counts to $<20,000/\text{mm}^3$. The patient is taking no other medications, and her physical examination and other laboratory evaluation are normal.

Question

Discuss the options for therapy in this patient.

Case (3)**(15 Marks)**

A 32-year old female presents with a persistently painful, stiff and swollen right wrist following a fall 5 months ago. X-ray of the wrist at the time of the accident showed fracture of the distal radius, which has subsequently healed on follow-up radiographs. However, her symptoms persist.

On examination, there is warmth, erythema and hyperalgesia on the right wrist. There is also a reduced range of active movement at the right wrist. There are no other swollen or painful joints.

Questions

1. What will most likely explain this presentation?
2. Mention the types of this disease
3. Present the differential diagnoses for this patient
4. Mention a characteristic X-ray finding you suspect in this patient
5. Which other modality may be helpful in the investigation of this condition?
6. What is the most worrying complication of this condition
7. Describe treatment options you can offer in your facility to this patient

Case (4)**(15 Marks)**

A 63-year old known case of rheumatic disease has developed nephrotic syndrome and a renal biopsy is performed. This reveals deposits in the mesangium and capillaries which stain pink with congo red and appear as green birefringence when under polarized light.

Questions

1. What is the diagnosis?
2. What is the likely underlying disease?
3. Mention other rheumatic diseases most commonly complicated by this condition
4. Determine other tissues can be biopsied for diagnosis of this condition
5. Describe the treatment and prognosis of this condition

37. A 25-year-old woman with SLE has had difficulty with severe thrombocytopenia. Previous bone marrow biopsies showed increased numbers of megakaryocytes and no other abnormalities. Past therapy with high doses of corticosteroids has been successful in raising the platelet count to normal levels, but tapering to 20 mg/day has resulted in a progressive decline in platelet counts to $<20,000/\text{mm}^3$. The patient is taking no other medications, and her physical examination and other laboratory evaluation are normal. Discuss the options for therapy in this patient. Treatment is recommended for platelet counts $<30,000/\text{mm}^3$. There are several therapeutic options to consider in this patient with autoimmune thrombocytopenia. One consideration would be splenectomy. If the patient had idiopathic thrombocytopenic purpura (ITP) without SLE, this would probably be recommended. However, the value of splenectomy in lupus-related thrombocytopenia has been debated, and its use is controversial. Some studies (retrospective and anecdotal) have suggested a high rate of failure in maintaining adequate platelet counts long term. Other reports (small case series) maintain that splenectomy is as valuable a long-term therapy in SLE as it is in ITP. Considering that the patient has no other severe problems from SLE and is a young woman, splenectomy would be a reasonable option. Rituximab may be considered in patients who have failed steroids, and possible use as a first-line agent is currently under investigation. Rituximab can induce a durable response, but the rate of response at >1 year is only 18% to 35%. Thrombopoietin receptor agonists (romiplostim) are also considered in patients who have failed steroids; however, they are expensive (\$55,000/year) and thrombocytopenia usually recurs when they are stopped. A variety of agents have been used as second-line agents. One option is the addition of an immunosuppressive or cytotoxic drug such as azathioprine (up to 2.5 mg/kg/day) or mycophenolate mofetil. This addition may decrease platelet destruction and allow the prednisone dose to be tapered. Azathioprine and mycophenolate are less toxic than cyclophosphamide and would be preferred in this setting. Cyclosporine A, vincristine, and dapsone have also been used as second-line agents. Another option is danazol, an androgen that increases platelet counts and allows the steroid dose to be decreased. Doses of 800 mg/day may be necessary, and the androgenic side effects in a young female may be troubling. On a separate note, high-dose intravenous immunoglobulin (IVIG) 2 g/kg (400 mg/kg/day \times 5 days) has been a very effective therapy to raise platelet counts acutely. This treatment can be used in preparation for splenectomy or if the patient showed signs of bleeding. Because of its cost, however, repeated treatments with IVIG are not a reasonable long-term therapeutic option. For Rh-positive nonsplenectomized patients anti-D is another possible first-line agent.

Aliaa Omar El-hady

الحالة الرابعة Amylodosis on top of RA

Aliaa Omar El-hady

الحالة الثالثة reflex sympathetic dystrophy

Mohammad El Gawish Nice cases

Samarino Helal MD Exam second part Commentary, Model answer

By Prof Dr/ **Abdelmoaty Afifi**

رابط التحميل:

**Physical Medicine,
Rehabilitation Mansoura Faculty of Medicine
and Rheumatology Department**

**MD Exam- Second Part
Commentary**

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Time

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(15 Marks)

A 25-year-old woman with SLE has had difficulty with severe thrombocytopenia. Previous bone marrow biopsies showed

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Question

Discuss the options for therapy in this patient.

Case (3)

(15 Marks)

A 32-year old female presents with a persistently painful, stiff and swollen right wrist following a fall 5 months ago. X-ray of the wrist at the time of the accident showed fracture of the distal radius, which has subsequently healed on follow-up radiographs. However, her symptoms persist.

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Questions

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3. Present the differential diagnoses for this patient

4. Mention a characteristic X-ray finding you suspect in this patient
5. Which other modality may be helpful in the investigation of this condition?
6. What is the most worrying complication of this condition
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Case (4)

(15 Marks)

A 63-year old known case of rheumatic disease has developed nephrotic syndrome and a renal biopsy is performed. This reveals deposits in the mesangium and capillaries which stain pink with congo red and appear as green birefringence when under polarized light.

Questions

1. What is the diagnosis?
2. What is the likely underlying disease?
3. Mention other rheumatic diseases most commonly complicated by this condition
4. Determine other tissues can be biopsied for diagnosis of this condition
5. Describe the treatment and prognosis of this condition

MODEL ANSWER

Answer of case (1)

(15 Marks)

1. Differential diagnosis of the case includes:

- A. Fibromyalgia
- B. Polymyalgia Rheumatica (PMR)
- C. Inflammatory Myositis
- D. Noninflammatory Myopathy

- The recent onset of symptoms (6 months) makes consideration of an inflammatory process likely. Proximal muscle weakness suggests myopathy
- Non inflammatory myopathy is characterized by proximal weakness but no pain
- Fibromyalgia is characterized by diffuse muscle pain, but no objective weakness
- PMR is characterized by muscle pain and stiffness, but no objective weakness

Common causes of proximal muscle weakness with elevated CK

Inflammatory myositis compared to non inflammatory myopathies which includes:

- Hypothyroidism
- Hypokalemia - Normally, blood potassium level is 3.6 to 5.2 (mmol /L).
- Alcoholism
- Drugs: Zidovudine (AZT) & HMG-CoA reductase inhibitors (The “statins”)

2- The diagnosis is Polymyositis based on:

Proximal muscle weakness

May have characteristic skin involvement: Heliotrope eyelids, Gottron's sign,

Shawl sign & The V sign :

Diagnosis is confirmed by:

Elevated Creatine Kinase (CK) levels:

Total CK reference value: 38-120 ng /ml

EMG findings:

Characteristic *EMG findings in Polymyositis* include: Short duration, Low amplitude, polyphasic motor units; Fibrillation potentials and Positive sharp waves

Muscle biopsy: Lymphocyte cellular infiltrates

3- Treatment:

- Prednisone 1–2 mg/kg, as initial therapy
- Methotrexate or Azathioprine is often added
- Intravenous immunoglobulin in rapidly progressive or refractory cases

Answer of case (2)

(15 Marks)

- Treatment is recommended for platelet counts <30,000/ mm³. There are several therapeutic options to consider in this patient with autoimmune thrombocytopenia.
- Considering that the patient has no other severe problems from SLE and is a young woman, **splenectomy** would be a reasonable option. However, the value of splenectomy in lupus-

related thrombocytopenia is controversial. Some studies have suggested a high rate of failure in maintaining long term adequate platelet counts. Other reports (small case series) maintain that splenectomy is as a valuable long-term therapy in SLE as it is in ITP.

- **Rituximab** may be considered in patients who have failed steroids, and possible use as a first-line agent is currently under investigation. Rituximab can induce a durable response, but the rate of response at >1 year is only 18% to 35%.
- **Thrombopoietin receptor agonists** (romiplostim) are also considered in patients who have failed steroids; however, they are expensive and thrombocytopenia usually recurs when they are stopped.
- Addition of an **immunosuppressive** or **cytotoxic drug** such as azathioprine (up to 2.5 mg/kg/day) or mycophenolate mofetil. This addition may decrease platelet destruction and allow the prednisone dose to be tapered. Azathioprine and mycophenolate are less toxic than cyclophosphamide and would be preferred in this setting. Cyclosporine A, vincristine, and dapsone have also been used as second-line agents.
- **Danazol**, an androgen that increases platelet counts and allows the steroid dose to be decreased. Doses of 800 mg/day may be necessary, and the androgenic side effects in a young female may be troubling.
- High-dose **intravenous immunoglobulin** (IVIG) 2 g/kg (400 mg/kg/day \times 5 days) has been a very effective therapy to raise platelet counts acutely. IVIG can be used in preparation for splenectomy or if the patient showed signs of bleeding. Because of its cost, repeated treatments with IVIG are not a reasonable long-term therapeutic option.

- For Rh-positive nonsplenectomized patients anti-D is another possible first-line agent.

Answer of the case (3)

(15 Marks)

1. What will most likely explain this presentation?

Complex regional pain syndrome type I. It is characterized by sensory, vasomotor and sudomotor changes. In later stages there may be muscle atrophy.

2. Mention the types of this disease

There are 2 types of CRPS – Both cause similar symptoms.

- Type I results from trauma to a limb and
- Type II (also known as causalgia) follows partial nerve damage.

3. Present the differential diagnoses for this patient

- Infectious arthritis (CBC, ESR, SF culture)
- Rheumatoid arthritis (ESR, CRP, RF, S.C nodules)
- SLE (Rash, serositis, renal, CBC, ESR, ANA, C3& C4)
- Scleroderma (Esophageal dysmotility, pulmonary, ANA,Scl 70)
 - Peripheral neuropathy(no edema, glove & stock hyposthesia)
 - Rotator cuff tear (drop arm, localized)
 - Paraneoplastic syndrome (ovarian carcinoma)
- Remitting seronegative symmetrical synovitis with pitting edema (ESR, MRI, response to steroids)

4. Characteristic X-ray finding you suspect in this patient

Regional periarticular osteoporosis (patchy or mottled osteopenia in < 50% of pts)

5. **Other modality which may be helpful in the investigation of this condition** Three phase bone scan (Tc 99): there is increased uptake early in the disease & can be normal as disease progress
6. **The most worrying complication of this condition** Stiff joints & muscle atrophy of the hand which become non-functional
7. **Describe treatment options you can offer in your facility to this patient**
 - **Physical therapy** (□ Massage, □ US □ Electroacupuncture □ TENS)
 - **Antiinflammatory agents** (□ NSAIDs □ Ketorolac in an IV regional block □ Corticosteroids)
 - **Sympathetic blocks**
 - α -1 adrenergic blockers: □ Oral Prazosin, terazosin □ IV phentolamine
 - α ₂ adrenergic agonist: Oral, patch, or epidural clonidine
 - Counterirritants: Topical capsaicin
 - **Anticonvulsants:** □ Phenytoin □ Carbamazepine □ Gabapentin □ Pregabalin
 - **Antiosteoporotic therapy:** □ Calcitonin □ Oral alendronate (40 mg/day)
 - **Immune modulation** (new): IV immunoglobulin (IVIG)
 - **Stop ACE inhibitors**
 - **Tricyclic antidepressants and serotonin and norepinephrine reuptake inhibitors**
 - **Calcium channel blockers**
 - **Establish rapport with the patient**, provide emotional support
 - **Thermal biofeedback, relaxation training, alcohol and tobacco cessation**

Answer of the case (4)

(15 Marks)

1. *Diagnosis*

This renal biopsy is findings are of amyloidosis

2. *Underlying disease*

Rheumatoid arthritis is the underlying disease. RA can lead to secondary amyloidosis. The other options do not lead to the findings described

3. *Other rheumatic diseases causing this condition*

Older studies reported a 5% to 15% overall incidence of amyloidosis in rheumatoid arthritis, juvenile idiopathic arthritis, and ankylosing spondylitis.

With the new therapies available for rheumatoid arthritis, juvenile idiopathic arthritis, and ankylosing spondylitis, the frequency of systemic AA amyloidosis is much less today (<1%).

4. *Other tissues which can be biopsied*

Abdominal fat pad

Bone marrow

Rectal mucosa

Gingiva/labial salivary gland

Skin

5. *Treatment and prognosis.*

- Mobilization and clearance of amyloid deposits are possible.

- Control the underlying inflammatory disease. Potent biologic agents are available to control the inflammatory arthritides
- Eprodisate (Kiacta) is a new antiamyloid drug currently in clinical trials. It is a sulfonated molecule which competitively binds to the GAG-binding sites on SAA and inhibits fibril polymerization and amyloid deposition in tissues such as the kidneys.
- Median survival in patients with AA amyloidosis whose underlying inflammatory disease is not suppressed is 5 to 10 years with 40% to 60% dying of renal failure.

Case 38

Omer Mala Ahmed

December 25, 2015 · Ranya, Iraq

🔄Case:

35 years old (2month post-partum nursing woman) G2P2A0 presented to me with active poly arthritis for about 6 weeks duration with high inflammatory markers & high titer of RF .

▪ Diagnosis: RA

□ Your Advises Regarding TREATMENT?while She want to continue on breast feeding & her baby is 2 months old .



Omer Mala Ahmed Dear profs & Doctors
Howaida Elsayed Mansour , Amal El Ganzoury, Tamer Elfarahaty, Rageh M. Elsayed, Basant Esawy, Sherry Kamel, Mona Mansour, Mohammed Hassan,Mohamed Magdy, Mohamed Ismail.....

Abdelrahman Amer Recent findings: Although nonsteroidal antiinflammatory drugs (NSAIDs) in general are passed into milk in low doses, shorter acting NSAIDs are preferred, with caution for premature infants. Prednisone can be taken by nursing mothers, although when used at doses higher than 20 mg/day an interval of 4 h after dosing and prior to breastfeeding

is recommended. Hydroxychloroquine and sulfasalazine are compatible with nursing. Cyclosporine is generally allowed in lactating women, although a single infant was reported to develop therapeutic drug levels. Azathioprine (AZA) and tissue necrosis factor- α -inhibitors have little to no transfer into breast milk, with negligible levels measured in infant sera, and thus may be considered for use in lactating mothers. Methotrexate and leflunomide should not be used. Other biological RA medications have not been evaluated, and are, therefore, best avoided by breastfeeding patients. <http://www.medscape.com/viewarticle/823479>



Rheumatoid Arthritis Medications and Lactation

This review summarizes the available data for commonly used RA medications and their use during breastfeeding.

MEDSCAPE.COM

Sherry Kamel Dear dr. **Omer Mala Ahmed**, thanks for your intersted cases that you always share in our group ,regarding RA with lactation ,,With high inflammatory marker , you can give your patient steroid 10mg \day and hydroquine 200mg twice \day and cyclosporin 100mg twice \day

Omer Mala Ahmed Thanks for your always golden comments dear prof**Sherry Kamel** , Cyclosporine is immunosuppressive drug & is it safe in lactating mother ? You advice 100mg/ day or lower doses ?

Sherry Kamel Cyclosporine is safe in lactating mother and I recommended maximum dose as you said she has high inflammatory markers then after remission ,you can decrease the dose

Mona Mansour I agree with what Dr **Abdelrahman Amer** said and I would like to emphasis that sulphasalazine should not be used in mothers with preterm infants and regarding nsaids if used do not use long acting NSAIDs like piroxicams

Mohammed Hassan nice as usual dear dr omer . yes i think use 20mg/d prednisolone + HCQ200mg 1x2 + Ca and vit D, if persist : increase GC to 30mg/d. if persist: add Csp. and if persist oligoarth localGC injection

Howaida Elsayed Mansour Dear all, dear dr.**Omer Mala Ahmed** , pls use these drugs: hostacortine 10 mg daily + hydroquine 200 1x2 + and it is much more safe to wait for 4 hours after taking these drugs to lactate her baby + Ca and vit D you can add panadol on demand but Cyclosporine is contraindicated in nursing mothers dr.**Sherry Kamel**....pls read this article

<http://archinte.jamanetwork.com/mobile/article.aspx...>

[Unlike](#) · [Reply](#) · [7](#) · [December 26, 2015 at 12:18am](#) · [Edited](#)

Omer Mala Ahmed Thanks dear prof **Howaida Elsayed Mansour** for your Decision making comment. What I found from your fully informative link is that low dose steroids, HCQ & SSZ can safely be used in nursing mother , but I don't know is SSZ or HCQ is superior to be used in nursing mothers as it's written in posted link as following:

SSZ:

Lactation:Sulfapyridine is excreted into breast milk. Milk concentrations are approximately 40% to 50% of maternal serum levels. No adverse effects occurred in 16 nursing infants.^{64,68,69} One infant developed bloody diarrhea attributed to his mother's sulfasalazine therapy. The mother was a slow acetylator who had relatively high blood levels of sulfapyridine.⁷⁰ Based on this report, the American Academy of Pediatrics classifies sulfasalazine as a drug that should be given with caution to nursing women because substantial adverse events may occur in some infants.¹⁴ Anecdotal experience in women with inflammatory bowel disease suggests that sulfasalazine is compatible with nursing.

HCQ:

Lactation; Low concentrations of hydroxychloroquine are found in breast milk. Because of the slow elimination rate and potential for accumulation of a toxic amount in the infant,

breastfeeding during daily therapy with hydroxychloroquine should be undertaken cautiously. The American Academy of Pediatrics classifies the drug as compatible with breastfeeding.

i found a new information in this link about the safety of SSZ during pregnancy; its written that sulfasalazine can probably be continued during pregnancy. Indeed, of all the DMARDs, it may be the first choice in treating rheumatic diseases in women of childbearing age who are planning to become pregnant or are already pregnant.

Always nice information...

Thanks again

Howaida Elsayed Mansour This paper is very interesting as it shows the effect of DMARDs on fertility, pregnancy and lactation ...

Omer Mala Ahmed Yes Yes it's really very informative

Howaida Elsayed Mansour So if this regemin failed to control her illness you can add ssz 500mg /12 hours if all failed advise cessation of lactation and start MTX. ...!!

Sherry Kamel Good morning:thanks dr. Howida for your continuous up date us with interesting and unusual topics. I will read the paper after I come from my work today ...many thanks.

Basant Esawy Nice important topic as usual dr **Omer Mala Ahmed**

Prednisone +HCQ+SSZ is comparable with lactating mother
Prednisolon better to be taken 2-4 h before next breastfeeding
If failure stop breastfeeding and start MTX

lters

- Use of antiinflammatory and immunosuppressive drugs in rheumatic diseases during pregnancy and..

Inflammatory disorders such as rheumatoid arthritis (RA), systemic lupus erythematosus (SLE), and inflammatory bowel disease (IBD) often occur in women of childbearing age. When

considering treatment options, a major tenet of treating women during pr

UPTODATE.COM

Rageh M. Elsayed Morning all sorry belated I agree with my Drs and this link may be of value Safety of RA drug treatments in pregnant and nursing women

<https://rheumatoidarthritis.net> › safety-of-...

Mobile-friendly - Many drugs may also enter breast milk during lactation and may pose a risk to the nursing infant. ... The DMARDs methotrexate and leflunomide are both considered pregnancy category X drugs and ...



[RheumatoidArthritis.net](https://rheumatoidarthritis.net)

RA patient resources including symptoms, diagnosis, treatment, community, expert answers and daily articles.

RHEUMATOIDARTHRITIS.NET

Tamer Elfarahaty Prednisolone; HCQ & (Ca and vit D) are safest drugs in RA with lactation. SSZ is another option as it reach breast milk in small amount but better to be avoided and it also contraindicated in prematute infant for risk of hyper bilirubinaemia .

Blog » 11 Pearls for Pregnancy Management in Rheumatoid Arthritis

11 Pearls for Pregnancy Management in Rheumatoid Arthritis 📖

By Artie Kavanaugh, MD; Jack Cush, MD | 21 Aug 2015

Tamer Elfarahaty

5. **Pregnancy Does Not Induce RA**

Remission. Historically, RA remission during pregnancy has been estimated with >75% remission/improvement. However, more recent studies show that only 20-40% of RA patients achieve “remission” by the third trimester. While 50% may be in low disease activity, nearly 20% will worsen or have moderate to high disease activity during pregnancy and require further therapeutic intervention (<http://buff.ly/>

8. Anti-Rheumatic Safety during Lactation.

NSAID, but not COX-2 inhibitor, use is compatible with lactation. If using corticosteroids, reviews suggest that breastfeeding should occur >4 hours after dosing, especially with prednisone doses >40 mg daily. Breastfeeding is permissible with hydroxychloroquine, sulfasalazine and azathioprine use, but is contraindicated with methotrexate, leflunomide, cyclosporine or mycophenolate (theoretical risk; not actual data). TNF inhibitors (TNFi) have been found in breast milk, but not in infant serum; hence, breast feeding for women receiving TNF inhibitors might be a viable option, assuming there is a strong maternal need for such therapy post-partum (<http://buff.ly/1JIVIM7>),

20/10/2015

Mohamed Magdy Nice case , Dr **Omer Mala Ahmed** ,thanks to my prof and my colleagues , but I want to ask you , what the biological therapy you prefer in this case ????

Omer Mala Ahmed Dear dr **Mohamed Magdy** sorry for replying your question , i just saw your question tonight after dr **Samarino Helal** mentioned my name in a comment Although my case with postpartum RA is not a candidate for Biological therapies , but it was found that TNF inhibitors have been detected in breast milk but not in the infants serum, so Women should not be discouraged from breast- feeding on (TNFi)s especially infliximab, Etanercept , Adalimumab & certolizumab which they are compatible with breast feeding , but caution is recommended until further information is available for other (TNFi)s & other nonTNFi biologicals .

	Compatible peri-conception	Compatible with first trimester	Compatible with second/third trimester	Compatible with breastfeeding	Compatible with paternal exposure
Corticosteroids					
Prednisolone	Yes	Yes	Yes	Yes	Yes
Methylprednisolone	Yes	Yes	Yes	Yes	Yes
Antimalarials					
HCQ	Yes	Yes	Yes	Yes	Yes ^a
DMARDs					
MTX <20 mg/week	Stop 3 months in advance	No	No	No	Yes ^a
SSZ (with 5 mg folic acid)	Yes	Yes	Yes	Yes ^b	Yes ^c
LEF	Cholestyramine washout, no	No	No	No data	Yes ^a
AZA <2 mg/kg/day	Yes	Yes	Yes	Yes	yes
CSA	Yes	Yes ^d	Yes ^d	Yes ^a	Yes ^a
Tacrolimus	Yes	Yes ^d	Yes ^d	Yes ^a	Yes ^a
CYC	No	No ^e	No ^e	No	No
MMF	Stop 6 weeks in advance	No	No	No	Yes ^a
IVIg	Yes	Yes	Yes	Yes	Yes ^a
Anti-TNF					
Infliximab	Yes	Yes	Stop at 16 weeks	Yes ^a	Yes ^a
Etanercept	Yes	Yes	Second but not third	Yes ^a	Yes ^a
Adalimumab	Yes	Yes	Second but not third	Yes ^a	Yes ^a
Certolizumab	Yes	Yes	Yes ^a	Yes ^a	No data
Golimumab	No data	No data	No data	No data	No data
Other biologics					
Rituximab	Stop 6 months in advance	No ^f	No	No data	Yes ^a
Tocilizumab	Stop 3 months in advance	No ^f	No	No data	No data ^g
Anakinra	No	No ^f	No	No data	No data ^g
Abatacept	No	No ^f	No	No data	No data ^g
Belimumab	No	No ^f	No	No data	No data ^g

Downloaded from <http://rheumatology.oxfordjournals.org/>

Case 39

Wesam Goda

December 31, 2015

A case of HCQ hyperpigmentation of skin



Amr ElKaber Thanks Dr **Wesam Goda**

DrAlsaid Hallool Is it reversible.?

Wesam Goda unfortunately it takes long time to improve; may be years after stoppage of HCQ and steroids ttt

Amg Amg

hydroxychloroquine الغريب ان في كريمات تفتيح للبشرة مكونة من ال

Howaida Elsayed Mansour Oh this is very extensive pigmentation we need to exclude Addison syndrome by checking serum K and Na levels ...

Wesam Goda Dear Prof.Dr. **Howaida Elsayed Mansour** this patient is male SLE patient , on AZA 100 mg/d, HCQ 400 mg/d for 5 years , and soulopred 20 mg/day for 15 years !!, after dermatological consultation , drug eruption is confirmed

Howaida Elsayed Mansour Dear dr.**Wesam Goda** - as internist we must rule out addison's syndrome as a rare complication of lupus ...due to autoimmune adrenalitis. ..no organ is immune in lupus. .!

Aliaa Omar El-hady Nice case Dr. **Wesam Goda**.... thank you for sharing

Wesam Goda the k level of the patient is low

LAB. REPORT

Patient Name : محمد احمد الريمي
Sex : M
Ref. Doctor :
Print date : 29/03/2015 04:14:21 PM

Age :
Date : 29/03/2015
Order No. : 620
Serial No. : 36678

Biochemistry

Serum Electrolytes

Sodium	136	135 - 145	mmol/l
Potassium	3.3	3.6 - 5.3	mmol/l
Chloride	107	98 - 107	mmol/L

SAM MEDICAL CENTER
Signature:

Wesam Goda as we know in Addison's disease the K level should be elevated

Howaida Elsayed Mansour Yes dr. Wesam this is true.. now we ruled out Addison's

Amr ElKaber Well done Dr **Wesam Goda**

Case 40:

Omer Mala Ahmed

January 1 · Ranya, Iraq

2.5 years old girl presented to me complaining of left wrist swelling for one year duration, no pain to mild pain , no fever & no rigor , No skin rashes .

INVESTIGATIONS:

CBC:

Hb: 9.6 (anemia of Hypo chromic & Microcytic)

WBC : 6.2

Plt : 268 000

ESR : 46

RF & ANA : -ve

US : Wrist Effusion (Doppler not done to find evidence of Synovitis because we have no expert MSK US practitioner), the effusion is very mild & difficult to be aspirated.

Eye Examination: Normal .

***PLEASE FOR YOUR COMMENTS REGARDING DIAGNOSIS & MANAGEMENT?**





Omer Mala Ahmed My Dears Doctors & Profs , Flrst Happy new year to all of you, then as usual for your comments Howaida Elsayed Mansour , Bassel El-Zorkany, Amal El Ganzoury, Tamer Elfarahaty, Sherry Kamel, Basant Esawy, Rageh M. Elsayed,

Aliaa Omar El-hady Any other joint affection?? Any systemic manifestations?? You think it is a monoarthritis??

Omer Mala Ahmed Dear Dr [Aliaa Omar El-hady](#) ,No other joint affection, No systemic symptoms , really i don't think it's difficult to decide if it's mono arthritis or not because it's not the lower limb joint arthritis to be associated with morning limping or delay from getting out from bed , I asked parents many times if the child has more symptoms or avoid using this hand during early morning but they said it's the same all over the day ! So it's very difficult to decide its oJIA or not , to me this condition need Doppler US for detecting any evidence of synovitis or it need synovial biopsy before starting DMARDS.

Tamer Elfarahaty MRI is a good alternative if doppler US is not available to dtecet synovitis &early erosin.

Aliaa Omar El-hady Why it is difficult to aspirate?? May be septic as T.B. .. Is there is history of trauma ?

Omer Mala Ahmed Difficult because has just mild swelling & we need US guided aspiration because as you know in mild swelling specially in children it's difficult to aspirate without

traumatization .no history of trauma , the child has no systemic symptoms to say it's septic or TB , & the ESR is not too high & if we correct the anemia the ESR may be normalize !

Tamer Elfarahaty JIA persistent oligoarthritis . Ask ;examine for other peripheral joints ; back & hip pain ;search for hidden psoriasis & family history of psoriasis?? antiCcp .repeat ANA & Follow up . Local ccs injection & NSADs. If no response add MTX.

Basant Esawy JIA monarticular pattern is possible diagnosis as high ESR and pain threshold in this age is very high , I had patient 2 years old with fracture both radius and ulna and she was playing with me with the affected forearm

MRI for detection of early erosions , bone marrow edema and synovitis

Acpa ,according to Acr 2013 guidelines of managing oJIA can start NSAIDs and wait for MRI result for IA injection as per guidelines**Howaida Elsayed Mansour** Happy new year for all of you, dr. **Omer Mala Ahmed** I feel that this girl might not has arthritis. .so I need to confirm the presence of arthritis by MRI wrist and if possible guided aspiration and synovial fluid analysis as this is essential in monoarthritis to rule out septic arthritis ...ESR may be high due to iron deficiency anemia and if MRI came free she might have Rickets..!

Rageh M. Elsayed Good pm dear all yes oJIA may just presented only with mild swelling , pain or just limping in LL affection and the child appears completely normal . suspicious of monoarthritis may be traumatic ,infection or apart of early oJIA only with time other manifestations will appear I think we need to do MRI and second trial of aspiration you need only one drop to do synovial analysis any how put the child on NSAIDs and maintain ROM till we narrow DD good luck and Happy new year for all

Omer Mala Ahmed Dears all thanks for your informative comments .

The equation for ESR correction in anemia is as follows: $15 / (55 - PCV)ESR$, So in this child True ESR = $15 / (55 - 29.5)46 = 27$
The child has no personal or family history of psoriasis.

I sent the child to do Doppler US for evidence of synovitis (hyperemia) .also i will try to aspirate inshallah.

The child has this problem for one year duration without history of trauma. The X-Ray shows no signs of active disease like tumor or TB which if they are behind this situation there should be bone or joint distraction during this long period of one year .what ever the cause i think it more goes with an indolent disease like JIA or something like that , yes as all of you guided me to aspirate or to do MRI to reach the diagnosis.

Really it's difficult to diagnose JIA when just single joint affected in upper limb because the child not give you direct history like this in adults & the parents not see any associated symptoms looks like seen in lower limbs as limping, gait disturbance & delay in getting out from bed

Mona Mansour MRI to confirm the presences of arthritis, full clinical exam to all other joints.

If MRI proves arthritis as suggested before by us (synovitis and effusion) .Sonography guided Local steroid

Case 41

Omer Mala Ahmed

January 2 · Ranya, Iraq

 Case:

33 years old 3 MP pregnant woman G5P4A0 , presented to me

complaining of Symmetrical poly arthritis involving small & large joints for two months duration, The nails are normal & the DIP joints are not affected .(but wrists , MCP , PIP , Elbows, Shoulders, knees, ankles , MTP Joints all are affected)

■ In history there is no Associated skin rashes or fever & rigor or mouth ulcers or photosensitivity or Raynauds .

■ The only important point in history is that ; the patient said that previously had yearly exacerbation of patchy skin lesions over the extensor surfaces of knees & elbows & dermatologist told them at that time it's Psoriasis, but this year her skin lesions are not returned & improved!

■ Had history of low back pain & morning stiffness., Clinical tests revealed evidence of Rt SIJ affection.

🔄 INVESTIGATIONS:

■ CBC: Not remarkable

■ ESR: 50

■ CRP: Strongly positive

■ GUE: Normal

■ Brucella: -ve

■ RFT & LFT : Normal

■ RF(ELISA) : IgM: 79 iu/ml (positive) (range : 0.1-15)

■ Anti-CCP(ELISA) : 39 iu/ml (positive) (Range: 0.1-12)

■ ANA: -ve (ELISA)

■ X-Ray : !!! She was sen by an orthopedic before me & she not knew that she is pregnant & did for her Knees & LSS (AP) X-Rays .

There is evidence of Rt Sacroiliitis!

☐ DIAGNOSIS:

RA

✳ TREATMENT:

■ HCQ 200mg ~~x~~2

■ Prednisolone 20mg/ day for 2 weeks then i saw her today & the pictures taken today ; she is better but still has arthritis & pain, so I admitted her for taking 3 pulses of Solumedrole 500mg/day for 3 days .

- OMEGA 3 1000 cap / day
 - Ca1200+Vit D 800iu/ day
- *FOR YOUR KIND SUGGESTIONS REGARDING
DIAGNOSIS & TREATMENT





Azad Azad Malikov how will you proceed with her pregnancy?
is it possible to continue pregnancy with HCQ treatment?

Howaida Elsayed Mansour Yes dr. hydroquinone is completely
allowed during pregnancy. ..

Omer Mala Ahmed Dear profs & Doctors:

Howaida Elsayed Mansour, **Tamer Elfarahaty**, **Amal El Ganzoury**, **Basant Esawy**, **Sherry Kamel**, **Rageh M. Elsayed**, **Aliaa Omar El-hady**, **Ali Mursi**, **Mohammed Hassan**,

Wajeeh Mahmood She collect 10 point /10 of ACR/eular 2010
criteria >> RA

the symptomatic treatment with NSAIDs is authorized in first
trimester of pregnancy " category B".

Sherry Kamel good evening dear dr. **Omer Mala**....I wonder
how do patient has RA , and didn't enter in remission with
pregnancy !!!.....your patient may have psoriatic arthritis like
RA especially in presence of right sacroilitis , positive
rheumatoid factor doesn't exclude the presence of psoriatic
arthritis , but anyway medication that be used in pregnancy are

limited (small dose of steroid +HCQ) and mini pulse steroid as you describe.

Mohammed Hassan good evening dear dr.omer . And happy new year all my profs. . According to ACR criteria it's RA. but the Q is sacroilitis ?? Any way good management dear dr.omer but i prefer to use I.A steroids inj. In resisted joints and elevat oral dose of GC. AS I'm afraid of pulse in pregnancy i had no clinical experiance in safety of pulse in pregnancy. Excellent as usual ear friend dr **Omer Mala Ahmed**

Rageh M. Elsayed Good pm all nice case 1-I think the patient has psoriatic arthritis (RA pattern) as we have sacroilitis never seen in RA 2- antic ccp is +ve in PsA not in psoriasis 3- difficult to preduct behavior of the disease with pregnancy or from one pregnancy to other although 2/3 of RA and PsA have remission 4- HCQ and short acting CS are safe during pregnancy and also pulse solumedrol is category c

Howaida Elsayed Mansour Dear dr **Omer Mala Ahmed** , to me this is a case of RA/PsA overlape. ...it happens. Psoriasis may overlape with lupus or RA as she has fulfilled all the criteria of RA at the same time she has clinical data consistent with PsA and cant be explained by RA these are:

- 1-Unilateral sacroilitis,
- 2-Psoriatic skin rash
- 3- Swelling of the distal interphalengial joint of the little finger..if she is a case of pure PsA and just has RA pattern the RF should be negative.....furtunately enough the ttt is the same it is MTX my opinion is this baby shouldn't be allowed to complete for feer of the high possibility of congenital anomalies due to repeated x rays ask the opinion of gynecologist!!

Omer Mala Ahmed Thanks for your informative comment Dear Prof**Howaida Elsayed Mansour** , what's your advice regarding management of this case ?

Howaida Elsayed Mansour I wrote my opinion regarding ttt in the previous comment .. again my opinion is dont allow this pregnancy to be complicated. ..ask gynecologist for termination for feer of high possibility of congenital anomalies due to

repeated x rays exposure. .and then start MTX therapy with your regemin

Omer Mala Ahmed Yes prof **Howaida Elsayed Mansour** the mother exposed to two X-Rays when the pregnancy was 1MP (one LSS AP & the other Rt knee AP)

I told the family this may induce problems to the baby as congenital abnormalities although i saw many pregnancy cases with X-Ray exposure & the baby was normal.

Now the child is 3 MP & I suggested to terminate it because of future risks to the baby but the family refused to terminate pregnancy !

So i started to treat her with oral steroid & HCQ , i plan to give her 3 pulses of 500mg Solumedrole . Are you advice to give another drug in combination with HCQ like SSZ or AZA ?

Howaida Elsayed Mansour No dont give her more drugs due to these reasons:

1- SSZ / AZA will add little to active RA ...

2- Bec if congenial anomalies occur they will blame youthat you are the one responsible for these anomalies. ..!!!!

Omer Mala Ahmed Yes you are right & thanks for alarming me regarding this important point, really I should tell them again regarding the risk of congenital anomalies & fear them so as to not blame me in the future.

Do you think that just two X-ray exposures can induce congenital anomalies ? Especially one of them is away from the pelvis (knee) .

Howaida Elsayed Mansour No one knows. ..anything can happen it is at least a 50% 50% possibility . ..only god knows....

Omer Mala Ahmed MEGA REGARDS FOR YOUR GOLDEN ADVICES & INFORMATION

Write a reply...

Aliaa Omar El-hady Nice case as usual Dr. **Omer Mala Ahmed**..I think the patient has psoraitic arthritis RA pattern ... How about hepatitis C Ag?? May be it gives the manifestation of RA in this psoraitic arthritis patient.. HCQ and steroids are safe with pregnancy

Omer Mala Ahmed Thanks dr **Aliaa Omar El-hady** for your informative comment, HCV is pending tomorrow inshallah

Amal El Ganzoury hi dr Omer thanks for the interesting case. this case could be overlap of rheumatoid with psoriasis as my dear colleagues suggested .I would like to combine hydroxychloroquine with salazopyrinne to reduce the steroid dose if possible

Tamer Elfarahaty 1) I think this patient has coexistent RA & PSA which It is rare but it is reported. Seropositive polyarthritis with diagnosis of RA. Also psoriasis is sometimes may be one of dermatological manifestation of RA and sometimes antiTNF for RA management induce psoriasis like lesion .Update for RA ;pregnancy doesn't induce remission in all RA patients ;20% will worsen or with high to moderate DAS. 2) but Sacroilitis with PSA especially with inflammatory LBP &MS and not in RA 3) also low titre (but not high) RF& anti CCP are acceptable in PSA (RA like) but it more seen in old age or children . Sacroilitis must be confirmed later by MRI . You are right in Treatment

Sherry Kamel Although I read that not all pregnant RA will be undergo remission,in practice all my RA pt(more than 100) had remission in pregnancy!!!

Rageh M. Elsayed **Sherry Kamel** last week i have one of my old patient with RA got pregnant with severe activity in the first trimester

Omer Mala Ahmed Thanks for your golden comment dear prof **Tamer Elfarahaty** , what's your opinion regarding my management? Any further suggestions regarding the management ? Are you advice to terminate pregnancy because of X-Ray exposure in the first trimester? They did one pelvic Xray & one knee XRay in the first trimester

Write a reply...

Basant Esawy Dear Dr **Omer Mala Ahmed**

Thank you sharing interesting cases

For me it is either PSA vs PSA/ RA overlap which is rare

Pred 20+SSZ and HCQ full doses

Or pred 20 plus certilizumb if available till full term or other TNF biological but stop at 32 weeks

Pulse steroid is not recommended in pregnancy and also as a line of management of RA due to its hazards and if PSA or overlap psoriasis will flare up

But mini pulse steroid can be used at least to control her activity

Reassess after delivery , MRI sij and us dip joints

...

Case 42:

Omer Mala Ahmed

January 3 · Ranya, Iraq

 Case :

25 years old 5MP pregnant lady (G1P0A0) , presented to me complaining of left hip pain for 1week duration, no fever or rigor , god general condition apart from hip pain.

No history of trauma or previous back or hip problems.

O/E : limited internal & external rotations of left hip., Normal

back & SIJ Examination.

*INVESTIGATIONS:

■CBC :

Hb: 12.5

WBC : 13.000 □

Plt 255 000

■ESR: 75

■CRP :Strongly positive

■GUE : Normal

■Brucella: -ve

■RF : -ve

■S.Ca : 10.6

■S AKP : Normal

■S.Vit D : 14.93 (insufficient)□

□ Your advices regarding Diagnosis & treatment of this case ?

Department: BioChemistry		Result Time : 30/12/2015 03:52:25 PM		Result by : Hawar	
Test	Method	Result	Unit	Notes	Normal Range
Ca++ (> 90) y			mg/dl		8.2-9.6
Ca ++ (60-90) y			mg/dl		8.8-10.2
Ca++ (18 -60) y		10.6	mg/dl		8.6-10.0
Ca++ (12 y- 18 y)			mg/dl		8.4-10.2
Ca++ (24 m -12 y)			mg/dl		8.8-10.8
Ca++ (10 d - 24 m)			mg/dl		9.0-11
Ca++ (0-10) Days			mg/dl		7.6 - 10.4
Ca++			mg/dl		8.6-10.0
Alkaline Phosphatase		133.2			42-141

Department: Hormonal Assay		Result Time : 30/12/2015 03:52:25 PM		Result by : Hawar	
Test	Method	Result	Unit	Notes	Normal Range
Vitamin D3 (25-OH)					
Vitamin D3 (25-OH)		14.93	ng/ml		Deficient <10 Insuffecint 10-29 Suffecient 30-70 potential Intoxication :

Omer Mala Ahmed Dear profs & Doctors
Howaida Elsayed Mansour ,Amal El Ganzoury, Basant
Esawy , Tamer Elfarahaty

[Sherry Kamel](#), [Mohammed Hassan](#), [Rageh M.](#)

[Elsayed](#), [Mohamed Ismail](#),

[أم البراء رفيده](#) It may be idiopathic transient hip osteoprosis which occure in third trimester of pregnancy and selflimiting within 6-8 monthes ,and we use symptomatic ttt with avoidance of weight beering

[Howaida Elsayed Mansour](#) If it is pregnancy related condition then why the ESR is high and the CRP is strongly positive...

[Sherry Kamel](#) Good morning Dr. [أم البراء رفيده](#)..you are right idiopathic osteoprosis hip is one of common complications with or just after pregnancy, But in this case high inflammatory marker raise the possibility of real hip arthritis

[أم البراء رفيده](#) Pro Dr @Howaida Elsayed and Prof Dr [Sherry Kamel](#) many thanks for your reply ...

In pregnancy there is elevated ESR , and also UTI is very common in pregnancy that can elevate ESR and CRP so at first I can exclude UTI

THANKS again

[Howaida Elsayed Mansour](#)

[أم البراء رفيده](#) the elevated ESR in pregnancy is just a mild elevation to be around 35 not 75 like this case and CRP if becam positive it would be mild elevation also like 7 or 8 mg %not strongly positive and in history analysis one should take the whole clinical picture in consederation....

[أم البراء رفيده](#) Thanks Doctor

[Howaida Elsayed Mansour](#) This is an inflammatory monoarthritis of the hip for DD

- Septic arthritis
- Reactive arthritis
- Evolving systemic disease ??

For MRI and guided aspiration for any effusion and Augmentin 625mg /8 hours for 5 days + paracetamol + Calcium and vit D till confirmation of the final diagnosis .. if pain persists you can add SSZ

[Omer Mala Ahmed](#) Dear prof [Howaida Elsayed](#)

[Mansour](#) thanks for your nice comment, could SSZ helpful in

hip arthritis due to spondyloarthropathies like reactive arthritis?
& SSZ is safe during pregnancy?

Really this patient visited me few days ago & i diagnosed the case as reactive arthritis & putted her on short course Prednisolone 15mg/day for two weeks + Cefodox 200 mg 2 + Ca & Vit D + Paracetamol & with rest , to be seen after few days inshallah

THANKS AGAIN **Howaida Elsayed Mansour** No drug is absolutely safe during pregnancy but SSZ could be used in arthritis specially in ReA and acc.to the new ACR recommendations 2105 it is the best drug in peripheral arthritis of SPA even superior to MTX and it helps much in uveitis also but acc to ACR no role of systemic steroids in SPA at all even with peripheral joint affection , totally agree with your management keep us updated by the MRI..

Sherry Kamel Good morning dr. I am agree with dr. Howida we need to do MRI to confirm the diagnosis of inflammatory hip .also MRI will rule out iliopsoas bursitis which may simulate hip arthritis causing severe pain and limitations of ROM.

Abdallah El-Sayed Allam You should do US examination,,, the DD is big ranging from bursitis ,arthritis up to neuropathy . neuropathies around hip are not uncommon as Lateral cut n and peroneal neuropathy

Amal El Ganzoury in this case it is a hip problem which should be fully investigated we have high CRP which could be inflammatory or infective , full labo should be done Diagnostic Us would be helpful. we have definite insufficient vit D which should be replaced.

Rageh M. Elsayed GOOD AM dear drs thanks for your case dr omer1- totally agree with my colleagues a case of persistent mono arthritis for work up MRI or us guided aspiration analysis will be helpful 2- although vitamin d deficiency causes generalized body aches and tenderness but we have many patients of persistent lbp and joints pain improved dramatically

with vit d supplement and esr and crp was mild to moderate elevation but not to the level of your patient >3 folds

Basant Esawy Good afternoon everybody

I think as you mentioned all this is either articular or peri articular

Infectious versus inflammatory

So us , MRI and blood culture for all bacteria and fungi

Aspiration of synovial fluid if possible for analysis and culture

Dalia Hussien Kamel Very useful case,thanks for all

Tamer Elfarahaty I totally agree with opinion of my colleagues that this either inflammatory vs septic . Articular vs periarticular .synovial fluid analysis & MRI or US to confirm diagnosis .

Also vit D deficiency may aggravate the symptoms and need to be treated either vit D 3 3000 to 6000 IU / day (safe with pregnant)& calcium supplement with serum Ca monitoring every month to detect early hyper vitaminosis .Other option: 600000 IU single dose after delivery.

Omer Mala Ahmed Prof **Tamer Elfarahaty** What you mean by giving 600 000 iu single dose after delivery? You mean this bolus dose is not safe in pregnancy ?

Tamer Elfarahaty Yes no recommendation ;no sufficient studies for high bolus dose in pregnant with osteomalacia

Omer Mala Ahmed Thanks alot , so even 300 000 iu ampules are not allowed! , it's new information for me , Thanks again

Tamer Elfarahaty But up to 200000 IU single dose vit D 3 is acceptable during pregnancy in some trials.

Omer Mala Ahmed Great thanks prof **Tamer Elfarahaty**

Case 43

Ahmed Abdulbari

January 6

Can the patient take benefit from non surgical spinal decompression?

A 48 female presented with severe LBP associated with Rt.sciatica for more than one year.

MRI & X-rays: spondylolesthesis

L4-5 (G1 out of 4)

We advice her either by surgical management or managed her by special programs of non surgical spinal decompression (machine of Physiotherapy & chiropractor from Hill DT/USA) She refused the surgical intervention, so we managed her with Physiotherapy

After she complete her 20 sessions, she was very happy of becoming without pain & her X-rays finding: there was difference by 5 mm



Rageh M. Elsayed Good work continue your abdominal st
beside stabilization programm with wt reduction

Aliaa Omar El-hady

Wesam Goda Well done Dr ☐

Sherry Kamel Dear Dr. Sorry for interruption, but
spondyloesthesis, is one of contrindication of spinal
decomposition for fear of increase the degree of vertebrae
slippage

Ahmed Abdulbari Dear **Sherry Kamel**

Thanks for your comment

Now we can manage the spondyloesthesis (G 1& 2 not 3 & 4)
by this machine

Case 44:

Omer Mala Ahmed

January 4 · Ranya, Iraq

48 years old man presented to me complaining of back pain & stiffness , Bilateral knee pain with swelling of left side, bilateral stiff shoulders with maximum pain on Rt shoulder, bilateral triangular blueish scleral pigmentation, both Ear pinna are hard & looks like bony structures with some blueish discoloration.

The patient had no history of passing dark urine

He was seen by many doctors & manages as a case of disc prolapse & some times disc degeneration (both conditions may occurs in this situation) with out paying attention to radiological signs of the disks .

□ INVESTIGATIONS:

▬ CBC : UnRemarkable

▬ ESR :15

▬ CRP: -ve

▬ LFT & RFT : Normal

▬ Rf : -ve

▬ X-Rays :

.LSS: Calcification of intervertebral discs with vacuum phenomenon.

.Shoulders: Destructive OA changes.

▬ Diagnosis: Alkapton Urea (Ochronosis)

▬ Treatment:

▬ NSAID

▬ Steroid injection of Rt Shoulder

▬ Vit tab C 500mg ~~✕~~2

▬ Exercise for stif joints

▬ We have no Herbicide Nitisinone & to me it's risky to use it because of high incidence of Side effects.

▬ For your suggestions & advices on management of this case ?

With great regards.















Omer Mala Ahmed Dear profs & Doctors
Howaida Elsayed Mansour, Amal El Ganzoury, Rageh M. Elsayed, Sherry Kamel, Basant Esawy, Bassel El-

[Zorkany](#), [Mohammed Hassan](#), [Tamer Elfarahaty](#), [Wajeih Mahmood](#), [Aliaa Omar El-hady](#), [Mona Mansour](#)....

[Tamer Elfarahaty](#) Ochronosis with characteristic degenerative spine with disc calcification and ear & bluish sclera pigmentation. Aspirate left knee to rule out associated CPPD. Confirm diagnosis by estimation of homogentisic acid in 24 h urine. About role of nitisinone ; it is controversial and not approved until now.

[Omer Mala Ahmed](#) Thanks for your informative comment dear prof [Tamer Elfarahaty](#) , so what's an alternative drug that helping this patient? Could they get benefit from colchicine?

[Tamer Elfarahaty](#) I think just NSADs ; intrarticular Ccs vitC ,diet rich vit C with low protein plus physiotherapy

[Omer Mala Ahmed](#) Thanks alot prof [Tamer Elfarahaty](#)

[Wajeih Mahmood](#) according to UPTODATE:

Diagnosis >> The disorder is characterized by the excretion of urine that appears normal when fresh, but turns dark brown or black if left standing or after alkalization. The dark color is caused by oxidation of homogentisic acid, and alkaptonuria has also been called black urine disease. Cloth diapers that are washed in alkaline solutions will have dark brown staining.

Levels of HGA are increased in blood, urine, and tissue samples. The diagnosis is confirmed by quantitative measurement of HGA in urine. Tyrosine levels are normal.

Management: >> No effective therapy is available for AKU. Dietary restriction of tyrosine and phenylalanine will reduce the excretion of HGA, although the clinical effect is limited . The arthropathy mostly is not reversible, although diet may prevent further progression. Ascorbic acid, which inhibits the enzyme that catalyses the oxidation of HGA to the polymer with affinity for collagen, is given, but its efficacy has not been demonstrated for ochronosis . Nitisinone, which inhibits the second enzyme in the tyrosine catabolic pathway, decreased urinary HGA levels

by 95 percent in one short-term study . However, no clinical benefits (hip total range of motion and other measures of musculoskeletal function) were demonstrated in a randomized trial of AKU patients who already had significant arthritis. It is currently unknown whether early treatment prior to the development of musculoskeletal symptoms would be beneficial.

[Sherry Kamel](#) Thanks dr for this update information

[Omer Mala Ahmed](#) Big information, thanks Dr [Wajeeh Mahmood](#)

[Aliaa Omar El-hady](#) Thanks Dr. [Omer Mala Ahmed](#) for sharing this very interesting case.. I agree with D. [Tamer Elfarahaty](#) and D. [Wajeeh Mahmood](#)..this is the first time for me to see this case beyond the books.

[Howaida Elsayed Mansour](#) Dear Dr.[Omer Mala Ahmed](#) I have some questions around the case and the diagnosis:

1- It is essential in Alkaptonuria to have black urine (ask the patient to collect his urine in a glass jar and to leave it for sometime in fresh air) the colour should turn black due to oxidation of homogentisic acid...this is very chch of this disease thats why it is called black urine disease...if not this rules out the diagnosis..

2- Why during all these years the patient didnt complain as this illness is a type of in born error of metabolism that should be presented early in life - at least around age of 20, but he is now 48 years...!

3- I need to rule out gout and gouty arthritis with ear tophi before considering the patient with this very rare disease. .

4- Quantitative homogentisic acid in 24 h urine is essential to confirm or rule out the diagnosis

I would ttt him by colchicine full dose, NSAIDS, and local steroid injections, if uric acid is high I will add urocosuric agent like fuboxystate

[Basant Esawy](#) Nice case as usual dr [Omer Mala Ahmed](#)

Totally agree with my colleagues and your perfect management 24 h urine homogentisic acid to establish the diagnosis

[Rageh M. Elsayed](#) GOOD MORNNING ALL 1- acually i saw only one patient in my all practice unfortunately no cure even no

benefit from medical treatment available only decrease protein and maintain activity 2- for joint affected esp knee and hip total arthroplasty is a good option 3-also calcification in internal organ can happen my patient had prostatic calculi

Omer Mala Ahmed Dear prof **Howaida Elsayed Mansour** great thanks for your Questions

I took the urine of the patient & i told the lab to leave the urine sample for sometimes to see if the color of the sample change or not ? But the Lab man not removed the cap of the tube to allow the urine expose to the air & to complete it's oxidation, although it's color some what turned to black after 1/2 hr !



Omer Mala Ahmed Dear prof **Howaida Elsayed Mansour** the patient said that I felt pain & stiffness in my back with limitation of my back movements for about 20 years & was seen by many doctors & managed as disc problem & nobodies told him that he had inborn error of metabolism AKU , he said also more than 15 years felt that the color of his ear pinna changed to blue & then gradually they became hard looks like Bony Ear Pinna ! Also found the bluish triangle pigmentation of sclera more than 15 years ago, he was complained during the whole periods before but the diagnosis delayed !

I am also sorry that i not posted the X-Ray of both shoulders because they showed evidence of destructive process in both shoulders



Omer Mala Ahmed Rt shoulder



Howaida Elsayed Mansour Excellent dr.**Omer Mala Ahmed** and thanks a lot for sharing us this very rare and interesting cases ..

Omer Mala Ahmed Thanks for your Always golden comments Prof**Howaida Elsayed Mansour** , i learned allot from you & the comprehensive discussions with othe great & professional Colleagues

Omer Mala Ahmed Dear prof **Howaida Elsayed Mansour** we have no the 24 hr Quantitative Homogentisic acid assay in our Labs , any further suggestions regarding the case ?

Could colchicine help these patients with Ochronosis? If this drug help him it's a good news

[Howaida Elsayed Mansour](#) No need to do more tests... it is proved by turning the urine black when it allowed to stand for sometimes, regarding ttt no one has experience in treating such a very rare case...so try Colchicine for a month and there is certain herbal medicine gives excellent result this is the most important thing to do

[Howaida Elsayed Mansour](#)



[Omer Mala Ahmed](#) I will give this picture to the patient to obtain this Drug inshallah, thanks allot prof

[Wesam Goda](#) Nice case as usual Dr [Omer Mala Ahmed](#), and ur management is great but i think we also need to rule out the renal stones in this patient especially as he has a long history of the condition ..thx in advance ..

Case 45

Omer Mala Ahmed

January 6 · Ranya, Iraq

🔄Case :

22 years old student today presented to me complaining of neck pain & Radicular symptoms especially to both 4th & 5th fingers for more than one year duration.

☐ O/E : provocative Tests for Neurogenic TOS were positive.

☐ MRI Cervical Spine: Normal

☐ EMG : Proved TOS .

🔄Diagnosis: TOS

☐ Treatment:

▪ NSAIDS

▪ Muscle Relaxant

▪ Pregabalin 75 mg / night

▪ Stretching Exercises for Lateral Neck muscles.

✱After 2 months today i saw the patient & still complaining & not improved!

☐ For your Suggestions regarding Treating this case ? Great
Regards



Omer Mala Ahmed Dear Profs & Doctors **Howaida Elsayed** **Mansour** , **Rageh M. Elsayed** , **Tamer Elfarahaty** , **Mohammed Hassan** , **Muhammad Dughbaj** , **Amal El Ganzoury** , **Sherry Kamel** , **Aliaa Omar El-hady** , **Wajeih Mahmood** , **Basant Esawy**.....

Amr ElKaber May use Cervical Traction and P.T.

Aliaa Omar El-hady Thanks Dr. **Omer Mala Ahmed** for sharing this nice case.....I see that there is mild degenerative spine (posterior osteophytes) .. Ask about his occupation كثير منهم بيشيلوا احمال علي راسهم من صغرهم وبرضه اسال علي المخدرات اللي بينام عليها وشوف اذا كان بياخد مخدرات والا لا .. السن ده لازم الواحد يتحاور معاه..واذا كان عنده مشاكل في بيته او شغله... ولو لقيت كله تمام اديله حقنة ديبروفوس لا تكرر وغير مضاد الالتهاب وباسط العضلات وراقبه كويس ممكن يكون mononeuritis multiplex of vasculitis and this is the start

Rageh M. Elsayed Morning all thanks for your nice common case 1- for me x Ray showed for word head posture and rt tilt no increase in transverse process of c7 (almost normal)meaning not bone lesion 2-so it is of postural mal position for word head posture with rounded shoulder common with deskjops 3-in mechanical analysis of tos there are spasm and tension in scalene muscle and upper ribs fixation with shoulder fixator muscle imbalance esp levator scapulae pectoralis minor beside upper thoracic fixation 4-medical treatment with p t esp shock therapy is very effective in scalene release beside instruction is very important regarding forword head postur with chin chuck and release of scalene tension by Alexander technique is very effective +stretching of pectoralis 5- mobilization first and second rib upper thoracic mobilization gives good result 6 - always remember that tos is muscle imbalance syndrome of faulty posture and our role is to find out the firing contracted muscle or group of muscle to deal with.

[Aliaa Omar El-hady](#) thanks Dr. [Rageh M. Elsayed](#) for your expert explanation ... Shock wave is not allowed in every clinic... please put photos or videos for treatment of this postural malposition... also please point to the malposition in x-rays....many thanks

[Rageh M. Elsayed](#) Thanks dr [Aliaa Omar El-hady](#) we can use pulsed us 0.8 to 1 for 8 min on affected scalene and precaution to be posterior to carotid pulsation very important

[Rageh M. Elsayed](#) ISA I will try to post photos for MET for causative muscle for release

[Aliaa Omar El-hady](#) have you a photo in the correct US position please

[Aliaa Omar El-hady](#) thanks a lot

[Rageh M. Elsayed](#) First feel the carotid pulse then in side posture put us probe posterior over the pillar of cervical spine this is the position of scalene and it is away from carotid pulse

[Aliaa Omar El-hady](#) plz..what is the hazards to put it on carotid pulsation (a question may be asked from juniors who will do the session) as US is pulsed

[Rageh M. Elsayed](#) Even pulsed us it has thermal effect and contraindicated to put over main vessel like carotid



[Aliaa Omar El-hady](#) thanks

[Omer Mala Ahmed](#) Great thanks for your informative & Comprehensive analysis dear Dr [Rageh M. Elsayed](#) , hope you show us how we can perform release of scalene tension by

Alexander technique & stretching of pectorals muscles, also show us how we can mobilize the first & 2nd ribs with pictures . Really daily I expose to more than one case with this problem & till now I don't know how i help these cases perfectly. You have more experience in treating these cases , hope again you give more detailed information with videos or pictures

Mohammed Hassan nice as usual dear dr omer . i completely agree with dr elsayed rageh . this is mechanical malpostural problem needs release of affected structures

Sherry Kamel Many thanks dr.**Rageh M. Elsayed** for your valuable comments

Sherry Kamel Dear dr**Omer Mala**, thanks again for your continuing uploading all these interesting cases that give us chance to discuss the cases from practical view..... Besides all exercises that were mentioned by dr **Rageh M. Elsayed**...I am sometimes injecting the paraspinal and trapezius muscle nearby C 7 spine(, 2cm lateral) by local anaesthesia , trimacilon, (kenacort ampule),,that relieve pain coming from associated myofascial pain syndrome

Aliaa Omar El-hady

عظيم جدا

Omer Mala Ahmed Great thanks for your informative comment dr**Sherry Kamel** , you are injecting just the trapezius muscles or also other muscles like Sternocleidomastoid muscles ? When we inject these muscles there's no risk of Nerve roots injury? Great regards

Sherry Kamel Just 2cm lat to C7,only one injection

Basant Esawy Nice discussion thank you all

Thank you dr **Rageh M. Elsayed** for these informations

I have also good results from myofascial pain injections in cases of chronic pain syndrome as Dr **Sherry Kamel** said but I use local anesthetics only

Aliaa Omar El-hady

يبقى المخدر حيودى الالم malposition بس لو هو كما قال د. السيد راجح فيه
[Rageh M. Elsayed](#) - [Sherry](#)
[Kamel](#) - [Basant Esawy](#)

[Rageh M. Elsayed](#) You are right dr [Aliaa Omar El-hady](#) mechanical problem solved with mechanical manuevers not chemicals but as a start to decrease pain we can use local injection of soft tissue in trigger points and you will find many in upper traps 1 scapulae rhomboid sub occipital etc

[Basant Esawy](#) Yes de [Aliaa Omar El-hady](#) you are right
I am talking in general in chronic pain syndromes in which the pain persist even after treatment or adjuvant with the main course of treatment

It can be repeated for multiple sessions

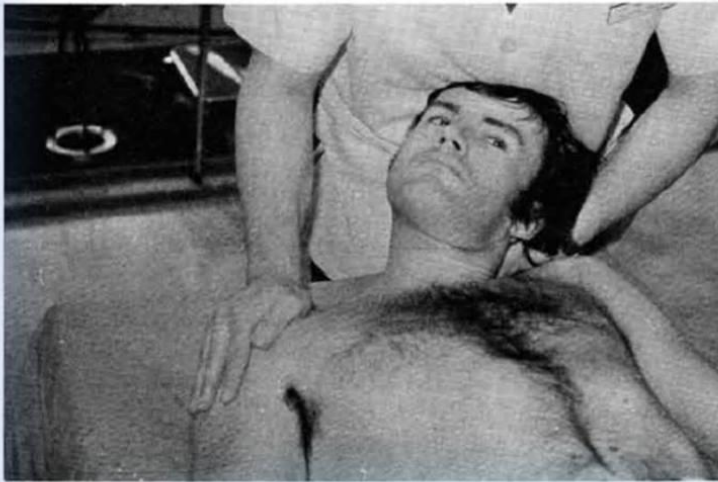
[Aliaa Omar El-hady](#)

يبقى بعد ما نحقنه لازم نعمله التمرينات علشان ترجع تانى (كيروبراكتيك)

[Tamer Elfarahaty](#) Nice case and valuable discussion . I Agree with Dr [Rageh M. Elsayed](#) . Neurogenic TOS due to poor shoulder girdle posture (no Cx rib & no vasomotor evidence) . So we need first to remove aggravating factor : habitual carrying heavy objects ; avoid thick pillow ;prone position in sleeping ;sport habits (swimmer) and ergonomics modification. Any tension in scalene muscle result in elevation of 1st and 2nd ribs which lead to decrease size of thoracic outlet space. So, Our target to open thoracic outlet and increase elasticity of scalene muscle . 1) Passive stretch of both scalene & pectoralis .2)Increase anterior &posterior mobility of 1st &2nd rib 3) mobilization exc. for scapula &sternoclavicular joint. (all exc .need high experience and good training). Also Increase dose of pregablin as patient tolerability. Last comment ; in a proximal root compression ;rule out also associated distal entrapment (Double crush).

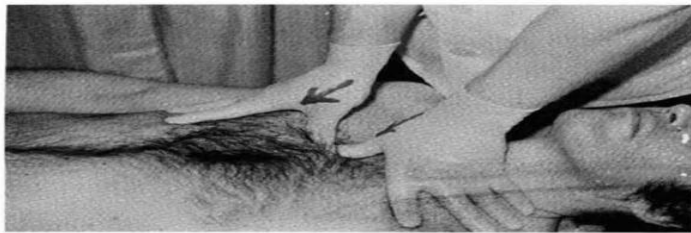
[Tamer Elfarahaty](#)

N.B The muscle stretching should always be done in a slow, gradual manner. Stretching of the scalene muscles should not be performed if there is an irritation of the brachial plexus in which traction on the plexus causes pain. **Deep sustained** pressure over the belly of the muscles can be used to induce relaxation. **The pectoral** muscles are the second group of muscles to be stretched



Stretching of the scalene muscles. The Therapist's right hand is stabilizing the patient's shoulder.

Tamer Elfarahaty



Anterior articulation of the 1st and 2nd ribs. (Each rib is done separately.)

5- Massage of the shoulder girdle musculature. A deep kneading massage is given to those muscles that have lost their elasticity due to muscle guarding and/or emotional tension.

6- passive scapula-thoracic flexibility exercises.



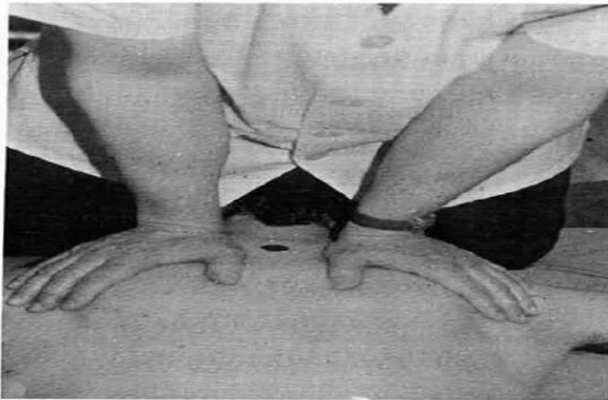
Scapula-thoracic flexibility exercise that consists of a passive circular movement

Scapula-

Tamer Elfarahaty



Posterior articulation of the 1st and 2nd ribs on the right side with the cervical column locked. The therapist's left hand is maintaining the patient's cervical spine in left side flexion and right rotation. (Each rib is done separately.)



Springing of the 1st and 2nd ribs creating a separational stress at the costovertebral joints

Tamer Elfarahaty



Mobilization of the scapula in the cephalad, caudal, medial, and lateral directions.



Rotary movement of the scapula upon the chest wall

Tamer Elfarahaty

III) Home Program

1- shoulder girdle circumduction exercise



2- The patient should not carry heavy objects (e.g., a heavy shopping bag) in the hand (or arm)

or slung over the shoulder on the affected side. If carrying a heavy object on the involved side is unavoidable, he should keep his shoulder elevated (shrugged) while carrying the object. The patient should also avoid physically stressful tasks that require pulling, pushing, or lifting with the affected arm

3- The patient should avoid sleeping on the affected side and in the prone-lying position. With the head on a pillow (especially a thick pillow), the cervical spine in the prone position is placed in forced rotation and hyperextension.

4- The patient is to modify occupational postural habits and body mechanics which precipitate or exacerbate his signs and symptoms.

5- For female patients, bra straps should not be tight and should be stretch straps. For the woman with pendulous breasts, a strapless longline bra may help diminish the patient's signs and symptoms.

6- The patient is to avoid physical activities that result in hard or rapid breathing. These activities may recruit the accessory breathing muscles (the scalene) which elevate the 1st rib.

7- The patient should avoid any activity that results in backward bending of the head or elevation of the affected arm over the head.

8- The arm should be positioned below shoulder level in rested position

9- If the patient has an acute episode of his symptoms, instruct him to pull his shoulders up into the shoulder shrug position as far as possible and hold them in this position for 30-60

Omer Mala Ahmed Great thanks for your informative comments dear prof Tamer Elfarahaty , Great Mona Mansour Physical therapy includes heat, massage stretching those are done for the scalenii and pectoral muscles as the entrapment may be under the inferior border of pec minor, medical treatment should include in addition of NSAIDS muse relaxants and neurotonics

Mohammed

[v.youtube.com/watch?v=2mnasAQFMwg...](https://www.youtube.com/watch?v=2mnasAQFMwg...)

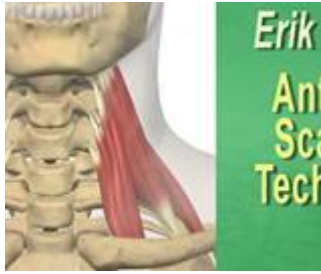


08 Mobilization to Increase Scapular Mobility

YOUTUBE.COM

Mohammed

[w.youtube.com/watch?v=X8Vxqrln_E...](https://www.youtube.com/watch?v=X8Vxqrln_E...)



Deep tissue myofascial release for Anterior Scalenes

YOUTUBE.COM

Mohammed Hassan <http://www.youtube.com/watch?v=wre->



7 Cervical Scalenes Stretch

Mohammed

[w.youtube.com/watch?v=PDt2ttAk5QU...](https://www.youtube.com/watch?v=PDt2ttAk5QU...)



Case 46

Omer Mala Ahmed

January 9 · Ranya, Iraq

🔄Case:

23 years old lady presented to me complaining of Rt hip pain & limping for 1 month duration.

She was not toxic just in pain.

- ☐ ☐ The condition not associated with fever or rigor
- ☐ ☐ She lost about 5 kgm of her weight in the previous few weeks
- ☐ ☐ No history of previous pulmonary problems
- ☐ ☐ Her father is a drilling worker , few months ago got cough & hemoptysis & was seen by a pulmonologist & diagnosed him as Dust induced pulmonary problem .
- ☐ ☐ O/E : limitation of internal & external rotations of Rt hip .No evidence of Sacroiliitis .

INVESTIGATIONS

▪ CBC: Normal

▪ ESR : 123

▪ CRP: Strongly positive

▪ Brucellosis: -ve

▪ X-Ray : Normal

▪ Pelvic MRI :

□ Evidence of Rt hip inflammatory problem with Oedematous changes involving the head , neck & metaphysis of femur.

□ Normal SIJs .

▪ I advised her to do Biopsy, but she refused.

□ I decided to put the patient on a course of anti Tb Drugs .

▪ today she visited me again after completing an initial 2 month of combination of four Anti TB drugs (Rifampin + INH + Pyrazinamide & Ethambutol)

▪ she got great benefit , Mild - no pain , no limping & her weight increased 3Kg , No more limping & she can go comfortably without filling pain.

▪ I decided to continue on Maintenance course of combination of two anti TB drugs (Rifampin + INH) for the next 10 months

because Extra pulmonary TB need treatment for 12 months (1 year)

🔄What's your advices for reaching the diagnosis in such cases whom refuse biopsy to reach confirmed diagnosis ?

I tried to do Tuberculin skin test , i did consultation to A doctor in TB center & he said that Tuberculin skin test is not helping your patient because it is used for latent TB or previous exposures even it's positive in all individuals who received Tuberculin vaccine injection.



Shawbo Mina Ali

HAR

Rania Artificial kidney

Avan

MR B1

HF

+LPI

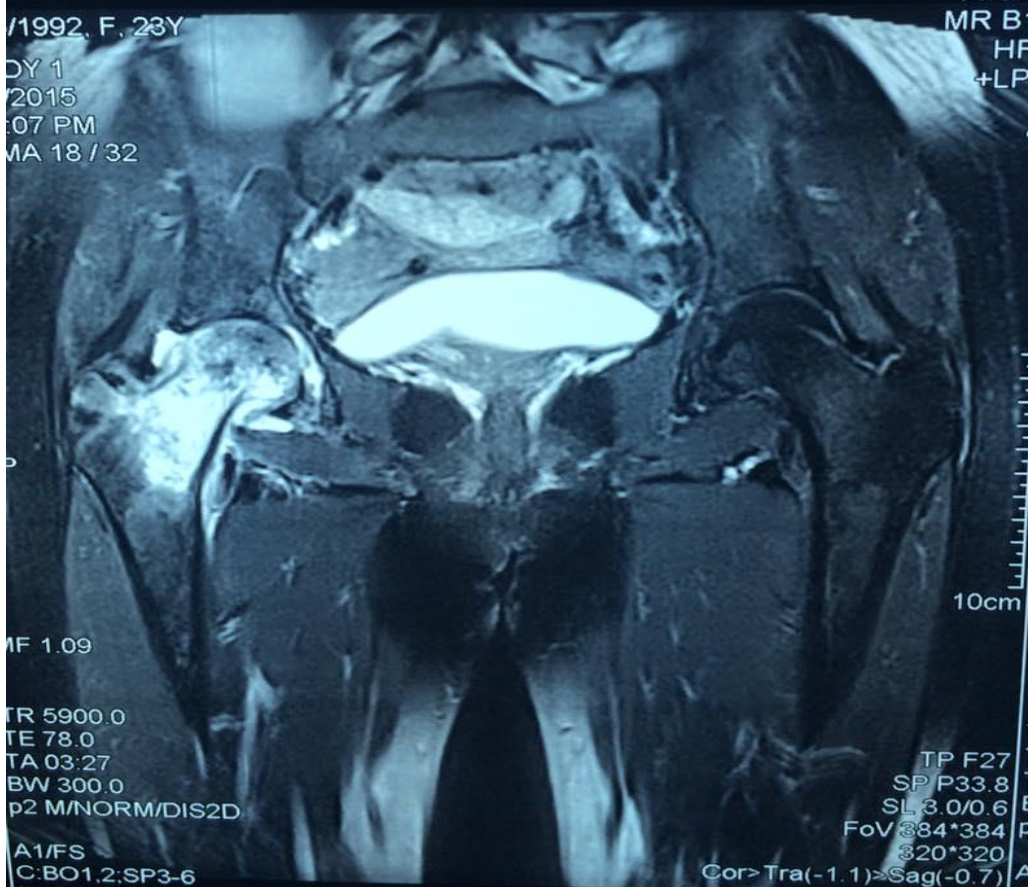
/1992, F, 23Y

DY 1

2015

07 PM

MA 18 / 32



10cm

MF 1.09

TR 5900.0

TE 78.0

TA 03:27

BW 300.0

p2 M/NORM/DIS2D

A1/FS

C:BO1.2;SP3-6

tseB2d1_18 / 148

Shawbo Mina Ali

HAR

TP F27

SP P33.8

SL 3.0/0.6

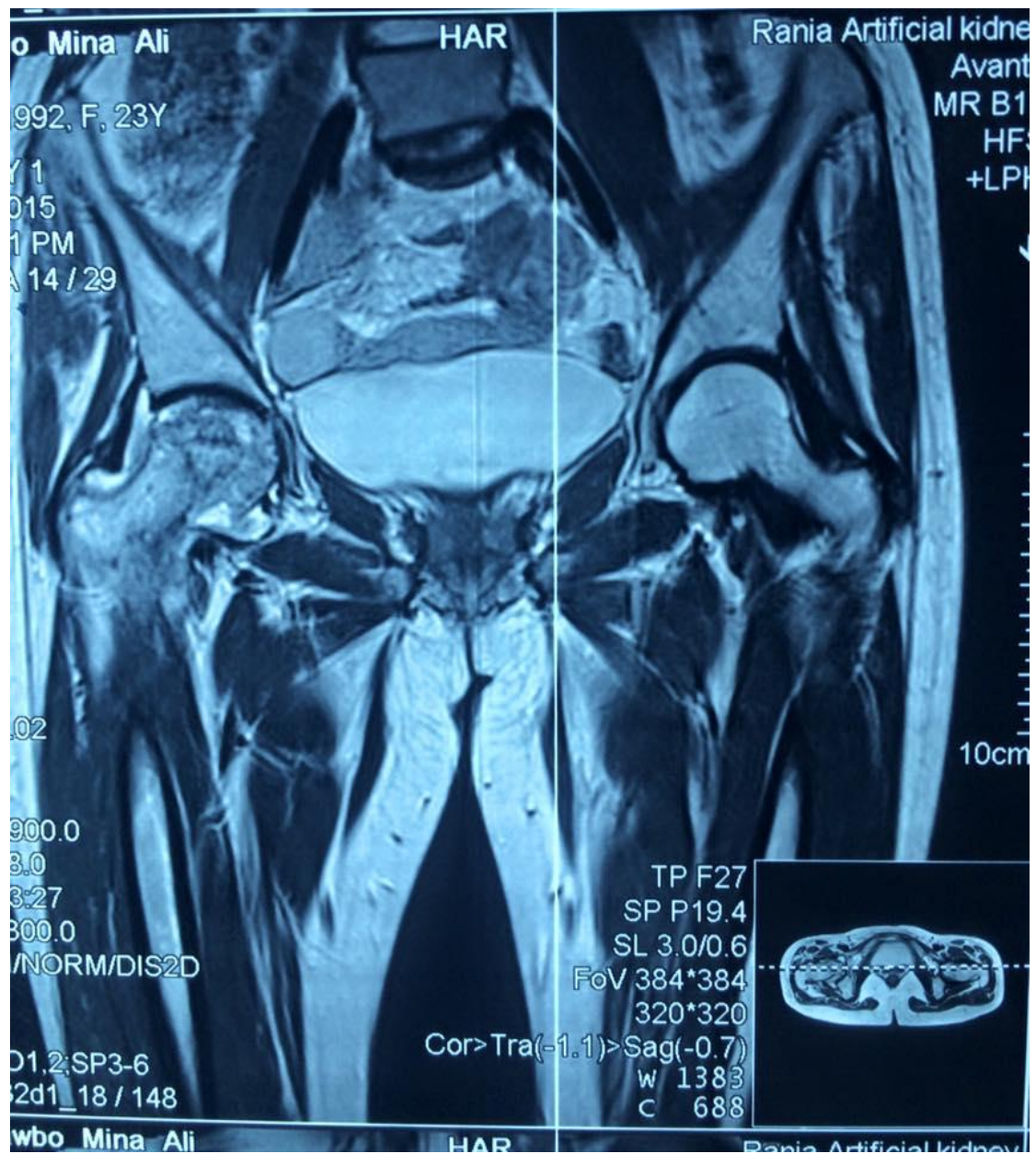
FoV 384*384

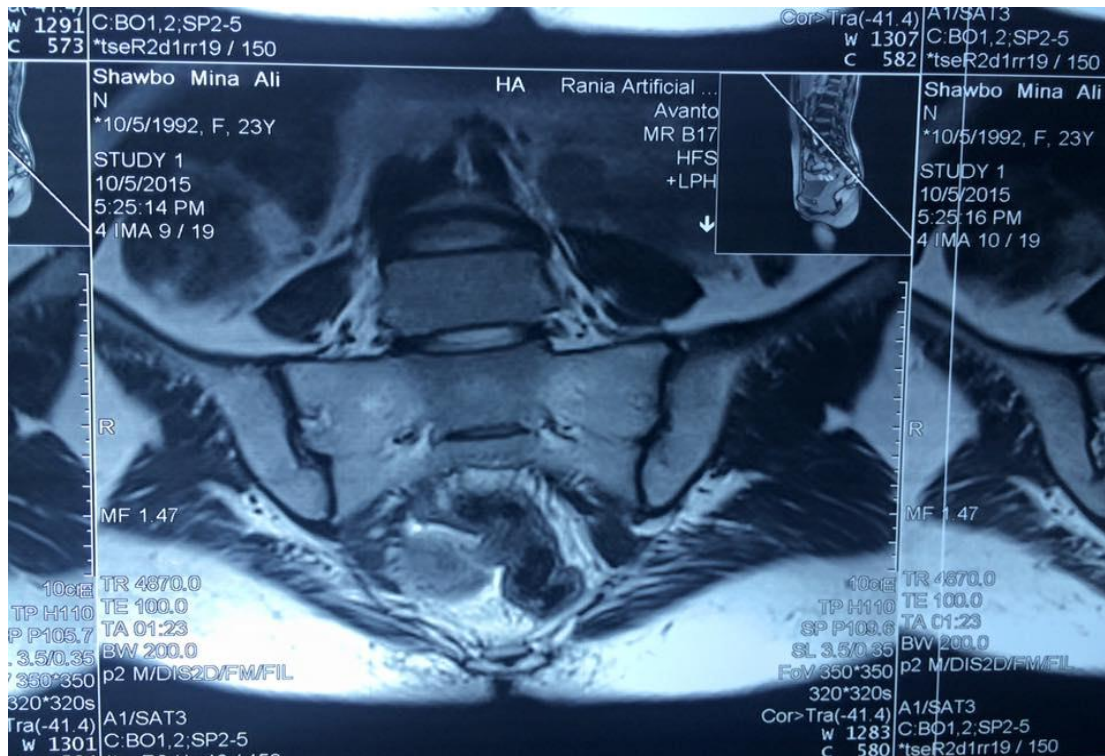
320*320

Cor>Tra(-1.1)>Sag(-0.7)

W 774

C 319





Abdelrahman Amer Thank you for sharing this interesting case

Abdelrahman Amer what about Tuberculin test or PCR for TB ?

Amal El Ganzoury it is very nice case. I would like to add why you did not do quanteferon assay for TB it is of help more. if the pt has cold abscess it will not heal. nice management.

Omer Mala Ahmed Dear profs & Doctors
Howaida Elsayed Mansour, Tamer Elfarahaty, Basant Esawy, Rageh M. Elsayed, Mohammed Hassan, Sherry Kamel, Mona Mansour, Amal El Ganzoury,

Mohammed Hassan nice case dear dr omer as usual. completely agree with your management ... you can use quantiferone test as prof Amal said

Mohammed

Hassan www.cdc.gov/mmwr/preview/mmwrhtml/rr5202a2.htm



Guidelines for Using the QuantiFERON

Prepared by Gerald H. Mazurek, M.D. Margarita E. Villarino, M.D. Division of Tuberculosis Elimination...
CDC.GOV

Amal El Ganzoury Thanks for sharing the guidelines for the quantiferon assay

Basant Esawy IGRA or quantiferone test is essential as Dr Amal El Ganzoury said

Also I have a comment in hip arthritis the MRI usually affecting the femoral head and acetabulum not like your case the affected femoral head and neck with minimal acetabulum affection which suggestive from radiological point of view is transient migratory osteoporosis
Synovial biopsy to establish the diagnosis of extra pulmonary TB arthritis is essential for diagnosis and quantiferone test , sputum analysis 3 samples for TB

Tamer Elfarahaty Dear dr omara ; As you mentioned TB skin test may be positive in previous vaccination and it is not dependable alone . If negative you can repeat it after 1 to 3 weeks if you still suspect TB or in high risk patients. Do IGRA (but it sometimes give false positive with low Ccs dose). BAV for acid fast bac. Culture. Synovial biopsy for granuloma (but patient refuse !) .
2) I think anti TB regimen up to 9 months .

Case 47

Omer Mala Ahmed

January 17 · Ranya, Iraq

🔄 Today this 1.7 years old child brought to me because of limping, the family found that their child started to limp toward the Right side after falling & they noticed a swelling in Rt distal leg (proximal to ankle)

▬ The family said that the their child has morning limping! & gradually become better with movement.

▬ when I examined the child I found that also distal Rt leg also swollen but not to that extent of Left distal leg .

▬ The swellings were just proximal to the ankle joints & there's no evidence of ankle swelling or knee problem.

▬ On arranging Plain X-Ray to find any evidence of fracture , I found X-ray findings of Rickets .

□ □ INVESTIGATIONS:

• CBC : Normal

• ESR : 38

• CRP : 24 (normally < 12)

• S.Alk.Phosph : 258 •high(Normally < 143)

• S.Ca : Normal.

• S.Vit D : pending.

□ □ Diagnosis: Rickets .

👤 For your opinions regarding:

□ □ How we manage this case ?

□ □ Can Rickets cause elevation of acute phase reactants & morning limping?

Great regards



Omer Mala Ahmed Dear prof & doctors
Howaida Elsayed Mansour , Basant Esawy, Tamer

Elfarahaty, Rageh M. Elsayed, Mohammed Hassan, Mona Mansour....

Mohammed Hassan good morning dear dr omer i think ANA. RF. and MSUS ankle are important to exclude coincident inflammatory conditions. and start to ttt rickets with vit D. and i think active rickets may increase APRs

Basant Esawy About ttt

Treatment for rickets may be administered gradually over several months or in a single-day dose of 15,000 mcg (600,000 U) of vitamin D. if the gradual method is chosen, 125-250 mcg (5000-10,000 U) is given daily for 2-3 months until healing is well established and the alkaline phosphatase concentration is approaching the reference range. Because this method requires daily treatment, success depends on compliance.

Any acute state of post traumatic condition may associate with inflammatory process , traumatic tenosynovitis manifests as morning pain and stiffness as venous return associated with metabolites accumulation

I do not think that rickets associate with acute phase reactant , so rule out concomitant infection

Close follow up and NSAIDs if deteriorating or frank arthritis investigate

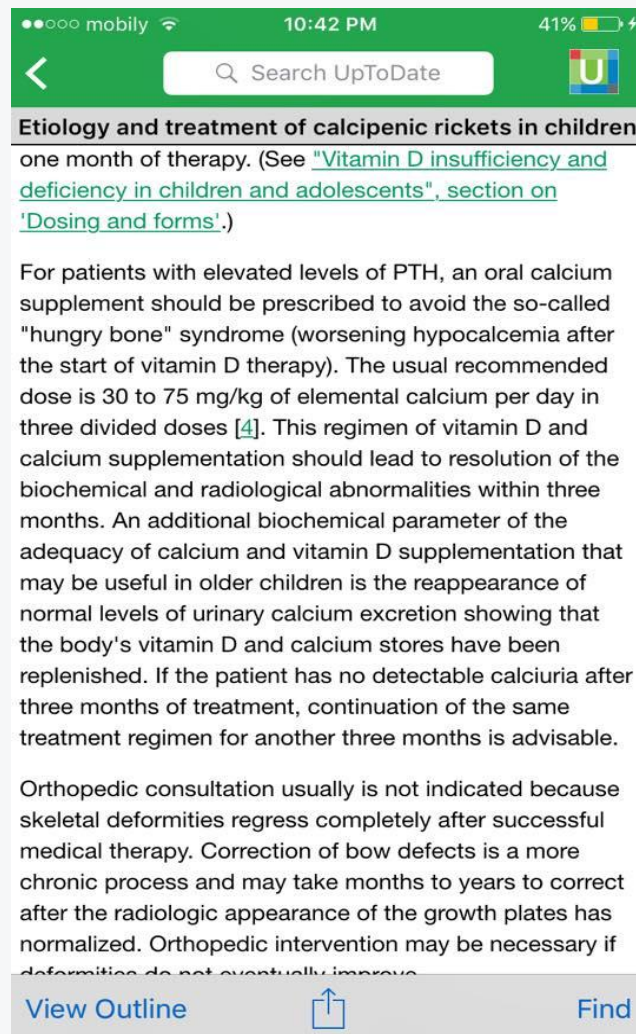
Be careful of green stick fracture which can occur in this age with rickets and you need AP/ lateral and oblique view in the affected area **Omer Mala Ahmed** Great thanks dear Dr **Basant Esawy** for your well & informative comment, the (600 000 iu) bolus dose is not change with the age & weight of the child? It's given in a single dose & no need for repetition or maintenance low dose Vit D orally ? This dose will cure every child with rickets? We need to give Calcium in addition to vit.D to Children with rickets ?

Basant Esawy This is the recommendations in medscape , Dose adjustment usually below one year and you should also follow with Pedia

I would prefer daily dose but compliance is the problem
If you have hyperparathyroidism calcium will be essential to avoid bone hunger syndrome

Omer Mala Ahmed Thanks Dr **Basant** , but in every case of Rickets there's no secondary hyperparathyroidism ?

Basant Esawy



Omer Mala Ahmed Great great thanks Dr **Basant Esawy**

Omer Mala Ahmed Sorry Dr Basant, Just the last line in the photo comment not appeared ! Orthopedic referring is recommended if , can you post the photo comment again involving orthopedic referral?

Basant Esawy

Etiology and treatment of calcipenic rickets in children

Orthopedic consultation usually is not indicated because skeletal deformities regress completely after successful medical therapy. Correction of bow defects is a more chronic process and may take months to years to correct after the radiologic appearance of the growth plates has normalized. Orthopedic intervention may be necessary if deformities do not eventually improve.

An alternative treatment protocol is the so-called "stoss therapy," which consists of a high dose of oral vitamin D (600,000 int. units) given on a single day [22]. This amount of vitamin D approximately corresponds to a three-month course of 5000 int. units per day and should be sufficient to induce healing of the growth plate within three months. Stoss therapy may be advantageous when compliance with therapy and/or follow-up is anticipated to be a problem [4,23]. However, such high doses of vitamin D can lead to hypercalcemia. Doses of 150,000 or 300,000 int. units appear to be equally effective, and are associated with less risk of hypercalcemia [24]. Finally, in older children, a modified higher dose approach has been successfully used, particularly when there is concern about adherence to a daily regimen. The regimen consists of weekly doses of 50,000 int. units vitamin D for two to three months.

Monitoring — Serum calcium, phosphorus, alkaline phosphatase concentrations, and urinary calcium/creatinine ratio should be measured four weeks after the start of therapy in children who are being treated for vitamin D-deficiency rickets. At this time point, serum calcium and phosphorus levels should have normalized,

Etiology and treatment of calcipenic rickets in children

Monitoring — Serum calcium, phosphorus, alkaline phosphatase concentrations, and urinary calcium/creatinine ratio should be measured four weeks after the start of therapy in children who are being treated for vitamin D-deficiency rickets. At this time point, serum calcium and phosphorus levels should have normalized, and alkaline phosphatase should have started to decrease towards the reference range. The urinary calcium/creatinine ratio may still be low. These tests should be repeated monthly until doses are adjusted downward to a typical daily replacement amount. This typically occurs by three months of therapy, at which time radiographs can be obtained to document the healing of rachitic lesions.

If the radiographs do not show evidence of healing, or biochemical parameters are not improving, the possibility of poor adherence to treatment, malabsorption of vitamin D, or other forms of rickets should be considered. Consideration of an alternate diagnosis is particularly important when the original biochemical profile had borderline values. As an example, modest elevations in serum PTH are occasionally observed in X-linked hyperphosphatemia (XLH), leading to an erroneous diagnosis of calcipenic rickets. (See ["Overview of rickets in children"](#).)

Monitoring is also important as to ensure that no toxicity has occurred, particularly if the vitamin D dose was erroneously dispensed or administered. We have encountered hypercalcemia in the setting where high doses were continued for a longer duration than intended

January 20 at 12:10am

80 years Old female with both stiff shoulder but more at right side ,bed ridden from long time she already do physiotherapy twice weekly but gradually she acquire bone deformity especially at lower extremity

What is the expected dignasosis and investigation she have injection for osteoprosis





Aliaa Omar El-hady Thanks Dr **Shahenda Hedaya** for sharing this nice case.... but what is her present history, medical history, examination , her investigation (CBC, ESR, CRP, Rheumatoid factor, ANA, kidney & liver functions, urine analysis) , x-ray on hands, feet, spine & sacroiliacs..... please you have to complete data to help in diagnosis & ttt

Shahenda Hedaya Calcium 8.8

Vit d 42.6

Ast 23

Alt 10

Ggt 8

Tsh 1.26

Ft4 0.9

Creatinine 0.7

Radiology both knee and ankle joint OA changes with osteopenic texture no x-ray for hand but by exman normal range

of motion except DIP of lt hand

The complaint is sever bony ache all over the body with sever stiffness at the lt shoulder she is on prolia 60mg every 6 month solpadine 2 tab 3time a day

Diagnosis Htn ,hypothyroidism , old cva ,sever osteoprosis

Like · Reply · 1 · January 20 at 11:35am

Shahenda Hedaya Rf and ANA not done before

Shahenda Hedaya Last EsR is 46 H

Chemistry
Collection Date: 17-Sep-15
Collection Time: 6:46:00 PM

Units	Ref Range
5.8	[4.5-10.8]
3.65 L	[4.20-5.40]
10.3 L	[12.0-16.0]
31.3 L	[37.0-47.0]
85.8	[81.0-99.0]
28.2	[27.0-31.0]
32.9	[32.0-36.0]
13.5	[11.5-15.5]
10.8 H	[7.4-10.4]
280	[130-400]

Complete Blood Count
Collection Date: 17-Sep-15
Collection Time: 6:46:00 PM

Units	Ref Range
30.0	%
59.0	%
2.0	%
6.0	%
3.0	%
1.8	x10(3)/mcL
3.4	x10(3)/mcL
0.1	x10(3)/mcL
0.4	x10(3)/mcL
0.2	x10(3)/mcL

Special Hematology Investigation
Collection Date: 17-Sep-15
Collection Time: 6:46:00 PM

Units	Ref Range
46 H	[0-20]

Erythrocytes Sedimentation Rate (ESR)
Procedure: 46 H

Legend: * = Corrected, @ = Abnormal, C = Critical, L = Low, H = High, F = Female, # = Interpretive Data

Printed: 9/19/2015 2:35:08 PM
Request ID: 14403098
Page 1 of 1

Patient Name: MASHOUR, KAMLAH ALI
MRN: 02617752
Location: LAB

Aliaa Omar El-hady

full ROM؟؟ يعني الرجلين دي فيها

Aliaa Omar El-hady Drs. Howaida Elsayed Mansour-Mona Mansour- Basant Esawy- Nashwa ElShaarawy- Tamer Elfarahaty- Mohammed Hassan

Shahenda Hedaya The Rom in ok hands but the foot limited range of motion and stiffness

Basant Esawy This pt ambulatory or not

Skin is normal or not

Deformities developed over how many years

Please post the X-ray

CCP , rheumatoid f

Other co-morbidity or interstitial lung disease

Shahenda Hedaya The pt is bed ridden for mor than 3 years no ccp or rheumatoid factor done before

Shahenda Hedaya She will have intrathecal cortic steroid in the left shoulder

Mohammed Hassan what about pelvis? any stiffness? i'd like to addMSUS to shoulders and pelvis to exclude PMR

Tamer Elfarahaty History of DM . Duration of progression of deformity . Complain of patient. Roule out assocaited peak of RA in old age ; sclreoderma and also sarcidosis. CRP ;AntiCcp ; anti jo 1 ACE and hepatitis C . Xray of hand at least chest xray

Shahenda Hedaya No history pf DM

Mona Mansour This patient suffers from deconditioning with contracture , muscle atrophy, senility and osteoporosis, if she has no elevated acute phase reaction, no new signs or symptoms do physio, panadol joint for bones, air mattress and that's all.

Shahenda Hedaya Thanks to all prof for valuable support

Adrosy Al-Adrosy with Aliaa Omar El-hady and 6 others.

January 20

case ... 52 y o male .. recently turned HUB pcr -ve after receiving sovaldi therapy. .. presented with extensive skin lesions over back, abdomen, ul and both lower limbs ... red in colour .. not elevated. .. with ulcers over lateral malleolus and fingers his lab showed no positive data including that cryoglobulins were undetected in his serum ... please share your valuable experience. .. many thnx







Mona Mansour <http://www.healio.com/.../current-concepts-on-the-patient...>

Current Concepts on the Patient with HCV and
Cryoglobulinemia | HCV Next
HEALIO.COM

Aliaa Omar El-hady Thanks Dr. Taha Adrosy Al-Adrosy for sharing this nice case.... see this link please it will help so much.....<http://hepatitiscnewdrugresearch.com/conditions-outside...>

There are accumulating data regarding extra hepatic manifestation of HCV, such as rheumatologic...
HEPATITISCNEWDRUGRESEARCH.COM

Adrosy Al-Adrosy about this case ... what would be the appropriate management?

Aliaa Omar El-hady Howaida Elsayed Mansour - Mona Mansour- Basant Esawy- Mohammed Hassan- Tamer Elfarahaty- Rageh M. Elsayed- Amal El Ganzoury- Nashwa ElShaarawy- [Mohamed Magdy](#)- Geilan Ibrahim

Case 50

Abdelrahman Amer

January 21 at 12:03pm

50 years old male patient has psoriatic arthritis

*Psoriatic skin lesions

*Arthritis: Rt 1st MCP&PIP ,4th DIP ...Lt 3rd 5th MCP 1st PIP..MTPs

*HCV PCR +ve

*S.albumin 4 gm/dl..S.bilirubin 0.8..SGPT 37..S.creatinine 1

*US : enlarged cirrhotic liver

*CT abdomen : enlarged cirrhotic liver ..dilated patent PV ...
dilated patent splenic vein with dilated hilar collaterals

*CBC : HB14 ..MCV 91...WBC 4.9...PLT 119

*ESR 27 *CRP -ve * S.uric acid 5

As regard ttt options MTX &SZP and safety on liver condition
..Enbrel is excellent choice but expensive

Wajeeh Mahmood UPTODATE >>

~~~~~

Our approach — The paucity of data on the treatment of psoriasis in patients with hepatitis C makes the identification of the best approach to the treatment of these patients difficult. We agree with the first and second-line therapeutic approach outlined by the Medical Board of the National Psoriasis Foundation.

For patients with moderate to severe psoriasis and hepatitis C, we use UVB phototherapy in combination with topical therapy as our preferred first-line treatment. Treatment options for patients who cannot be effectively treated with these modalities include biologic TNF-alpha inhibitors, acitretin , and PUVA phototherapy, though data on the safety of these interventions are limited.

We consult a hepatologist prior to starting treatment with a TNF-alpha inhibitor. Patients treated with TNF-alpha inhibitors also should have baseline and periodic assessments of HCV viral load and liver enzymes (eg, every three months) [ 1,28 ]. Acitretin should be used with caution in this population, with periodic monitoring of liver function status.

Despite evidence suggesting that cyclosporine may inhibit replication of HCV, until further evidence confirms its safety in the hepatitis C population, we agree with the Medical Board of the National Psoriasis Foundation's designation of this drug as a third-line agent for psoriasis in patients with hepatitis C. Further study is required for conclusions regarding the use of ustekinumab for psoriasis in patients with hepatitis C.

**Aliaa Omar El-hady** Thanks for sharing this nice case.... I think it needs biological ttt for fear of hepatic failure. **Howaida Elsayed Mansour- Mona Mansour- Nashwa ElShaarawy- Amal El Ganzoury- Mohammed Hassan-Basant Esawy- Geilan Ibrahim**

**Abdelrahman Amer** Dear drs **Tamer Elfarahaty Omer Mala Ahmed**

**Omer Mala Ahmed** Thanks for sharing this interesting case dear **DrAbdelrahman Amer**.

□ □ Really The management of patients with psoriasis and concomitant hepatitis-C virus (HCV) infection is often difficult because treatments for hepatitis C, such as interferon- $\alpha$  and ribavirin, may trigger or exacerbate psoriasis and psoriatic arthritis. In addition, most systemic therapies for psoriasis, including immunosuppressants (cyclosporine) and other potentially hepatotoxic drugs (acitretin and methotrexate), are relatively contraindicated in HCV infection.

□ □ Increased levels of circulating TNF- $\alpha$  and TNF receptors have been reported in patients with hepatitis C, although the exact role of this cytokine in the pathogenesis of HCV infection is still unclear . However, there are scarce data regarding the safety of biological drugs in patients with hepatitis C .

Antagonists of TNF- $\alpha$  (etanercept and infliximab) have shown no adverse effect on liver function tests and viral load in patients with RA or PsA and HCV infection ,It was found that the above agents are effective and safe as adjuvant treatment to interferon and ribavirin in the management of patients with hepatitis C .

□ □ what remains to mention in your case is that : initiate anti-TNF therapy only in those with well-controlled HCV disease and need appropriate monitoring of his viral load & liver function.so management of your case needs collaboration between Rheumatologist & Hepatologist

**Abdelrahman Amer** Thank you

**Yara Tawfik** Great case Abd elrahman .. as the patient has peripheral seronegative arthritis , so ttt of choice are mtx or szs ,, i think in this case u try szs alone with monitoring of liver enzymes if no response , so enbrel

**Abdelrahman Amer** Thank you

**Basant Esawy** Nice topic and case for discussion

dr **Abdelrahman Amer**

In such case you try to control skin lesions with local ttt and arthritis can be ttt with SSZ if no response enbrel ( etanercept ) can be the second option for such case of hep c and PSA

It was mentioned before in 2012 ACR guidelines that etanercept can be used with hepatitis c in RA

And in the new guideline 2015 biologics can be used with approval and regular follow up with gastroenterologist

**Abdelrahman Amer** Thank you

**Abdelrahman Amer** SSZ safe with HCV?

**Basant Esawy** Yep it is safe



**Omer Mala Ahmed**

January 24 at 11:56pm · Ranya, Iraq

🔄Case :

35 years old female patient presented to me complaining of Rt Wrist arthritis for 1 week duration.

No history of trauma

No fever & no rigor

No skin lesions, no inflammatory back pain

Has Dysuria sensation

☐ INVESTIGATIONS:

CBC: Not Remarkable

CRP : 48 ( Strongly positive)

ESR :35

Rf & Anti CCP : -ve

GUE : pus cells :+

☐ Diagnosis: ReA

\*Treatment:

▪ Wrist local steroid injection

▪ SSZ 2000mg/ day

▪ Celecoxib 200mg / day

▪ Cefixim 400 mg/day for 10 days

🏥 For your kind opinions regarding:

1- my Diagnosis & lines of management?

2- for how long she should use SSZ ? Lifelong or limited period of time?

GREAT REGARDS

"



**Omer Mala Ahmed** Dear profs & Doctors  
Howaida Elsayed Mansour, Amal El Ganzoury, Tamer  
Elfarahaty, Basant Esawy, Sherry Kamel, Rageh M.  
Elsayed, Mohammed Hassan, Mona Mansour.....

**Amr ElKaber** Why ReA??????, with No H/O of fever ,  
infection , inf LBP, enthasopathy, Eye affection , Oral Ulcer  
\*\*\*\*\*Just only (Pus + -ve RF) YOU should Rule out (HCV,  
Thyroid), Also CBC Recommended

**Rageh M. Elsayed** Dear **Omer Mala Ahmed** thanks for your  
nice case acute attack of inflammatory monoarthritis only 1  
week duration with no other manifestation ???for DD  
I think it is Too early to judge  
· Edited

**Howaida Elsayed Mansour** Dear dr **Omer Mala Ahmed** this is  
an acute inflammatory monoarthritis of just one week  
duration...we can start the work up by aspiration of synovial  
fluid U/S guided and send for bacterial culture , gram and Zheil  
Nelsein stain to rule out TB/septic arthritis (TB arthritis is  
common at the wrist joint...) white cell count ...and still she  
might have any evolving inflammatory illness that not yet

completed. ..during this stag and untill the final confirmation of the diagnosis keep her on NSAIDS + Ciprofloxacin for 10 days (UTI) start SSZ after ruling out sepsis....TB or other....

ANA is needed and urine culture

**Omer Mala Ahmed** Dear prof **Howaida Elsayed Mansour** great thanks for your advices . Really I tried to aspirate but difficult to do it blindly as you said need US guidance.

What made me to not think about TB is that the ESR not so high , also what made me to not think about septic arthritis is the absence of systemic features & the joint has no features of sepsis ( redness & very Severe pain that not allowing any movements)

For how long we should wait to diagnose ReA ?

**Howaida Elsayed Mansour** This is not the common site for ReA ... (Knees/ankles) So we still need to rule out TB /septic arthritis with this very high CRP even if there is no redness or systemic features also please ask her about psoriasis or any family history of psoriasis/ uviitis. .. then we can start SSZ or other DMARDS accordingly

**Basant Esawy** Thank you dr **Omer Mala Ahmed** for sharing your cases

Totally agree with my colleagues

Rule out infectious causes

Do MRI to rule out kienbock disease or to prove inflammatory joint disease

**Mohammed Hassan** nice case dear dr omer. i think first rule out infection and crystal arthropathy so i think SF analysis is v.important plus MSUS or MRI wrist then I.A GC injection +NSAIDs + strong antibiotic . if resist short low dose steroids if persist give SSZ

thanks again dr **Omer Mala Ahmed**

**Tamer Elfarahaty** Acute monoarthritis for one week . So ;Need ist to roule out sepsis before ccs injection even with no fever . Reactive arthrtis is one of possibility and sometimes not preceed by GIT or Gentiourinary infection but it is not common in wrist

. CBC & Urine culture . Even in ReA we start by NSAIDs and follow up before add SSZ

**Ahmed Al Shambky** Dr. Omer thank u, I notice this bluish coloration on the dorsum of the hand similar to resolving ecchymosis also there is a red spot on dorsum of the wrist also there is oedema at the base of the thumb and minimal fullness of the dorsum of the hand if compared with the other , so this observations are true or false please tell me

## Omer Mala Ahmed

December 26, 2015 · Ranya, Iraq

2 years old boy presented to me two days ago , complaining of attacks of fever for 2 months duration. The condition first started as sore throat & fever , at that time was seen by pediatrician & diagnosed him as Tonsillitis & prescribed Antibiotic( Amoxicillin) for his condition & the sore throat was improved with Antibiotics but the child continued to have daily single attack of fever usually at the evening , every day between the attacks the temperature was normal.

▪The condition associated with marked loss of appetite, marked weight loss & severe malaise.

▪Also associated with joint pain in Rt Wrist & Rt knee (the mother said that her child point to these to joints for pain)

▪The condition not associated with skin rashes .

▪No Rigor

GO/E:

▪ No lymphadenopathy or organomegaly

▪ very mild swelling of Rt Knee in comparison to left knee , i not found swelling in Rt Wrist !

▪ at that time (7:30 pm ) the Temperature was 39 °C

□ INVESTIGATIONS:

□ CBC & Blood film:

▪Hb : 6.8 gm/dl □

▪WBC : 12000 □

▪RBC: 2.560 000 □

▪PLL 175000

□ BLOOD FILM:

▪RBC : Below Normal , Normochromic & Normocytic with marked Raux Formation

▪WBC : No immature cells seen

▪PLL: with in normal limits

▪Advised screening for inflammatory or infectious diseases.

□ ESR : 125 □

□ CRP: 48 (Strongly Positive ) □



- ☐ Hb-Electrophoresis: Normal
- ☐ S. Ferritin: 135.6 ( Normal )
- ☐ S.iron : 75 (Normal)
- ☐ GUE: Normal
- ☐ LFT & RFT : Normal
- ☐ CSF : Normal
- ☐ ASO: -ve
- ☐ RF : -ve
- ☐ ANA: -ve
- ☐ Abdominal US: No Organomegaly & No lymphadenopathy.
- ☐ CXR: Normal

\*DIAGNOSIS: sJIA

□ TTT:

- ☐ MTX : 7.5 mg / WK
- ☐ Folic Acid: 5 mg / WK
- ☐ Prednisolone Syrup (5mg/5ml) : 5cc ✕ 3
- ☐ Ca& Vit D Syrup
- ☐ Panadol Syrup on Need.

\* Your Suggestions About:

- ☐ Diagnosis & TTT?
- ☐ Need blood transfusion or not for his severe anemia?
- ☐ What's behind his low RBC mass?

GREAT REGARDS



**Omer Mala Ahmed** Dear Profs & Doctors:  
**Howaida Elsayed Mansour, Amal El Ganzoury, Tamer Elfarahaty, Sherry Kamel, Mohamed Ismail, Rageh M. Elsayed, Basant Esawy, Mona Mansour, Mohammed Hassan, ...**  
**Howaida Elsayed Mansour** Dear dr. **Omer Mala Ahmed** ,  
regarding this young baby with recurrent attacks of fever and severe normochromic normocytic anemia and starting thrombocytopenia with marked loss of weight and appetite please  
1st we need to rule out acute leukemia by bone marrow biopsy (not aspiration )  
, 2nd DD is familial hereditary fever syndromes (FMF)  
3rd DD is systemic onset JIA (low serum ferritin is not against sJIA) regarding the management rule out leukemia then either sJIA or hereditary fever syndromes will have nearly the same lines of ttt  
**Omer Mala Ahmed** Dear prof **Howaida Elsayed Mansour** thanks for your advices , after I putted the child on Steroid 2 days ago , today i saw the child again & the parents said that unlike the previous nights the child not experienced fever last night & the child's appetite improved in comparison

with previous days .

They have no family history of the same situation also.

I wil arrange BM examination & hope the result not goes with Haematological malignancies.

**Howaida Elsayed Mansour** Yes please because even in leukemias/ lymphoma fever may improve with steroids and also do Coomb's test ...we just need to rule out a fatal illness before considering him as sJIA

**Basant Esawy** Very nice case with cute little boy  
Totally agree with dr **Howaida Elsayed Mansour** you should rule out myeloproliferative disorder first as any disease can improve with steroid

Chronic infection also as brucellosis or malaria, and blood culture , chest x Ray also in spite 2 months history are recommended as a part of fever work up

**Omer Mala Ahmed** Thanks for your advices dear Dr **Basant Esawy** , Brucella is negative & CXR is normal, thanks again ; i will arrange BM examination inshallah

**Aliaa Omar El-hady** Nice case Dr. **Omer Mala Ahmed**... thank you for sharing

**Omer Mala Ahmed** Dears pros & Doctors

**Howaida Elsayed Mansour**, **Basant Esawy**, & **Aliaa Omar El-hady**...

Update regarding my case:

After you advised me to exclude hematological malignancies, I referred the case for a professional hematologist for screening , he did another time a very fine CBC & Blood film again, although I adviced the hematologist to do also BM Biopsy, but he didn't do it because he said that from the Blood film result the patient not in need of Bone Marrow Biopsy or aspiration & he reassured the family that their child has no hematological Malignancies, this is the Result of CBC & B.Film

التاريخ ٢٠١٦ / ٢ / ٦

لازود محمد

ID = LAZO MUHMMED  
SEQ = 6033  
DATE= 06/01/2016  
TIME= 15:25:34

BLOOD OT

Normal ranges

|                 |          |             |
|-----------------|----------|-------------|
| WBC = H 13.4    | $10^9/l$ | 3.5 : 10.0  |
| LYM = H 6.9OM   | $10^9/l$ | 0.5 : 5.0   |
| MID = H 1.6OM   | $10^9/l$ | 0.1 : 1.5   |
| GRAN= 4.9OM     | $10^9/l$ | 1.2 : 8.0   |
| LYM% = H 51.9OM | %        | 15.0 : 50.0 |
| MID% = 11.5OM   | %        | 2.0 : 15.0  |
| GRA% = 36.6OM   | %        | 35.0 : 80.0 |

|             |      |             |
|-------------|------|-------------|
| HGB = L 7.2 | g/dl | 11.5 : 16.5 |
|-------------|------|-------------|

|               |             |              |
|---------------|-------------|--------------|
| RBC = L 2.59  | $10^{12}/l$ | 3.50 : 5.50  |
| HCT = L 23.0  | %           | 35.0 : 55.0  |
| MCV = 88.5    | fL          | 75.0 : 100.0 |
| MCH = 27.9    | pg          | 25.0 : 35.0  |
| MCHC = 31.6   | g/dl        | 31.0 : 38.0  |
| RDW = 91.3    | fL          | 30.0 : 150.0 |
| RDW% = H 18.3 | %           | 11.0 : 16.0  |

|             |          |             |
|-------------|----------|-------------|
| PLT = 137   | $10^9/l$ | 100 : 400   |
| MPV = L 7.5 | fL       | 8.0 : 11.0  |
| PDW = 11.4  | fL       | 0.1 : 99.9  |
| PCT = 0.10  | %        | 0.01 : 9.99 |
| LPCR = 16.5 | %        | 0.1 : 99.9  |

Blood Film:

Retic; 10

Red cells are normochromic with anisocytosis. Polychromatic cells, microspherocytes, teardrop & occasional nucleated red cells are seen. ESR: blood sample was not enough.

Leucocytes: No abnormal cells seen.

Platelets are just adequate in number.

Conclusion: Hemolytic Anemia.

Direct coombs test & G6PD enzyme assay is advised.

Dr Hisham

N.

**Omer Mala Ahmed** I am also not sure about the previous Lab Result of S.Ferritin which was returned with normal level , so I advised to redo S.Ferritin again in a dependable Lab , & the result returned to my 2 years old case with very very high level !

التاريخ ٢٠١٦ / ١ / ٦

Plasma Ferritin = 310.7 ng/ml

Men, aged 20-60 years: 30-400 ng/ml  
Women, aged 17-60 years: 13-150 ng/ml

Ferritin (ng/ml) in children

| < 3 days | 3 - 30 days | 1 - 12 mth | 1 - 6 years | 7 - 12 years | 13 - 18 years | >19 years |
|----------|-------------|------------|-------------|--------------|---------------|-----------|
| 149-1350 | 42-509      | 26-288     | 11-92       | 10-72        | 15-92         | 13-150    |

Plasma Vitamin B12 = pg/ml

Reference Range: 191-663 pg/ml

Plasma Folate = ng/ml

Reference Range ng/ml

Adults males : 4.5 - 32.3  
Adults females : 4.8 - 37.7  
4 - 11 Years : 8.6 - 37.7  
12 - 19 Years : 5.0 - 27.2

**Omer Mala Ahmed** Now the child is on MTX 7.5 mg / wk Orally + Folic acid 5 mg on the day after MTX + Prednisolone Syrup (5mg/5ml) 5ml2 + Paracetamol Syrup on need & Ca+Vit D syrup 5 cc/ day .

Now the child is much better, not got attacks of Fever & Rigor, No more joint pain , His appetite & fatiguability markedly improved.

But yesterday his father called me & told me that their child get attacks of abdominal pain just one night per week ! Not associated with vomiting or diarrhea or bloody stool or urine color changes , just the child crying from abdominal pain & it improves with taking Paracetamol syrup after about one hour, I don't know what could be the cause?!

**Howaida Elsayed Mansour** Yes he is likely sJIA / haemolytic anemia as haematological malignancy was ruled out by pediatrician and s.ferritin came high.... (not like the 1st value)...but please exclude haemolytic anemia, check for the coomb's test and G6PD as this might explain all his symptoms



arthralgia , fever , abdominal pain, even the elevated serum ferritin. . there are many other reasons for this pain but the most important thing to tell his parents to observe any recurrence of this pains and to check the child temp twice daily (9 am and 9 pm)

**Omer Mala Ahmed** Great thanks Dear prof **Howaida Elsayed Mansour** for your golden advices , although the S.Bilirubin was done & normal , but i will recheck the TSB , Coombs test inshallah, also I will rearrange for the 2nd Abdominal US . Thanks again

**Howaida Elsayed Mansour** Haemolytic anemia was the suggestion of the haematologist..

**Howaida Elsayed Mansour** Please dr. **Omer Mala Ahmed** check also for serum G6PD as a cause of haemolysis as the elevated serum ferritin arthralgia, anemia and leucocytosis are all may be just due to haemolytic anemia..

**Omer Mala Ahmed** Ok dear prof **Howaida Elsayed Mansour** , thanks for your recommendations , i will arrange these tests inshallah

**Mona Mansour** Dear Dr. **Omer Mala Ahmed** I would like to order echocardiography for this kid to exclude the possibility of kawasaki disease. It gives,a similar clinical picture with high acute phase reactants

**Omer Mala Ahmed** Thanks Dr **Mona Mansour** for your recommendation, i will arrange it inshallah

**Basant Esawy** Thank u dr **Omer Mala Ahmed** for your great job

Totally agree with my colleagues

sJIA highly possible now but rule out other causes of hemolysis as G6pd also add ldh which is a marker of hemolytic anemia

The Blood culture was negative or not!!

Echo to rule out subacute bacterial endocarditis which also can be associated with hemolytic anemia but in such situation hardly to respond to steroid and immunosuppressive medication which make SIJA is highly suggestive

**Marwa Aldosoky** **Marwa EL-Sayad**

**Omer Mala Ahmed** Dear prof **Howaida Elsayed Mansour** are you advising me to give 3 mini pulse of 250mg/day for this little boy with this active disease so as to help in disease remission & early steroid withdrawal?

**Howaida Elsayed Mansour** This is in the 1st cycle only to induce remission but from the 2nd to the 6th cycles you will give single soluomedrol injection mini pulse 500 mg on 500 cc glucose 5 IV drip over 2 hours

**Omer Mala Ahmed** Sorry prof **Howaida Elsayed Mansour** your comment is not so clear to me ! This little boy which we excluded the hematological malignancies i try to give him 250 mg/ day Solumedrole for 3 consecutive days, is it good choice? I not understood your comment about cycles ? What you mean by cycles in Solumedrole pulses ?

**Howaida Elsayed Mansour** We call it (cyclic pulse therapy) bec it is given in monthly cycles in the 1st cycle only we give daily soluomedrol injection for 3 days but in each subsequent month ( called cycle) we give only single soluomedrol injection with or without endoxan ( eg if the case is lupus nephritis), actually 250 mg soluomedrol is enough bec your patient is very young (2 years) as this cases in our place is treated by pediatric Rheumatology not by internal medicine rheumatology. ...

**Omer Mala Ahmed** Thanks allot for your clarification dear Prof

**Omer Mala Ahmed** Dear prof **Howaida Elsayed Mansour** , the parents are very anxious regarding their child health so they visited another Rheumatologist & told them that it's too early to treat this child with Steroids or DMARDS, so he stopped MTX & Prednisolone!!! & he putted the child on Mefinamic acid syrup & Amoxicilline !!!

After 3 weeks they brought to me today with flare of arthritis &

attacks of fever .

So I decided to give this 14 kg child 3 consecutive daily 250 mg doses of Solumedrol & restarting again the MTX 7.5 mg/ week orally & keeping him daily steroid of 5 mg + Ca&Vit D .

I also planned to give the child monthly cyclic pulses of monthly 250mg for 6 consecutive months.

What's your further recommendations?

Great thanks ,

**Howaida Elsayed Mansour** Yes dear dr.**Omer Mala Ahmed** I agree with your lines of treatment but what about the coomb's test and G6PD levels ?? and please follow up his fever , arthritis , CBC and ESR...etc, if no response again bone marrow is strongly recommend ....

**Omer Mala Ahmed** Great thanks for your reply dear prof , really i advised the parents to do Coombs test & G6PD level but they said that their child became exhausted from huge number of investigations done before visiting me & they said give some time for the child to become investigation free & we will do it inshallah

**Howaida Elsayed Mansour**

معاهم حق طبعا...محتاجين هدنة قصيرة وان شاء الله الولد يتحسن مع العلاج الجديد

**Omer Mala Ahmed** Inshallah, Great thanks for your advices, you're Really Great

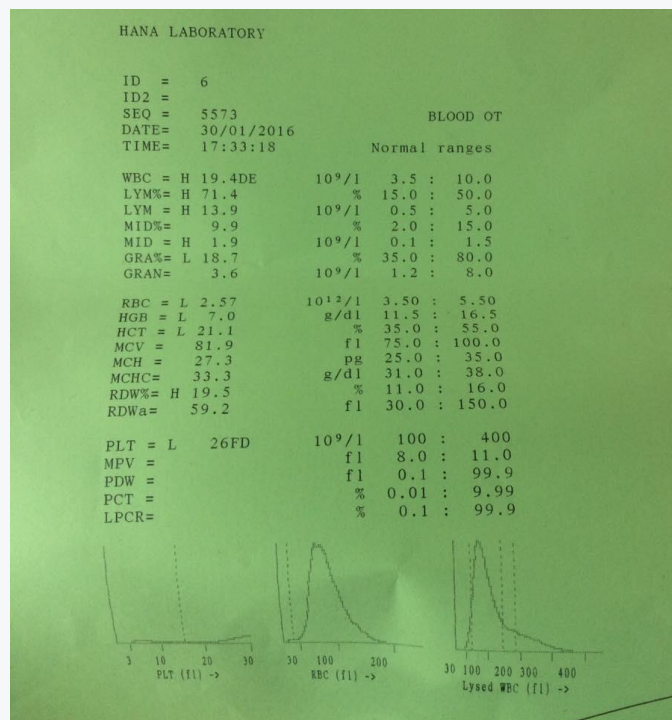
**Omer Mala Ahmed** Dear profs & Doctors

**Howaida Elsayed Mansour**, **Mona Mansour**, **Amal El Ganzoury** , **Basant Esawy**....

As i said previously that few days the child brought to me with flare of his condition ( Fever & arthritis & loss of appetite ... )

I gave him 3 mini pulses of daily 250 mg Solumedrol because he is just 13 kg in weight , after that i discharged the child to be seen again after 3 days , they brought to me again today & they said the child was improved from fever just two days & still has evidence of arthritis in ankles & knees & can not stand or walk , severe loss of appetite & today goot 3 attacks of Epistaxis because of severe thrombocytopenia , also RBC mass still low with marked anemia .

Whats your next advice ?



**Howaida Elsayed Mansour** Bone marrow biopsy immediately ..leukemia is the 1st possibility. ..as I said long time ago.....please do it now...! lower limb joints arthritis is very common in leukemias and in all haematological malignancy.

..also please do Coomb's test direct and indirect and G6PD level  
**Omer Mala Ahmed** You are Right Dear prof **Howaida Elsayed Mansour**& thanks for your always dependable advices & comments , but whats the fault of me & parents when the Prof of Hematology refused to do it because he saw that its not indicated !!!!

**Howaida Elsayed Mansour** Yes I know dr **Omer Mala Ahmed** but please stop MTX and dont give him any steroids till the bone marrow biopsy is done to rule out leukemia bec systemic onset JIA = Still's disease is the diagnosis of exclusion...and it doesnt cause cytopenias except if it complicated by macrophage activation syndrome (MAS) which also should be confirmed by bone marrow examination to exclude leukemia But dont refer the child again to the same haematologist. ...!! bec this is time wasting. ...the chance of cure is still present but we should move fast..

**Basant Esawy** Urgent bone marrow biopsy to rule out MAS versus malignancy as anemia with thrombocytopenia and leucocytosis

Stop immunosuppressive immediately , poor little boy

**Omer Mala Ahmed** Great thanks dear prof **Basant Esawy** for your advices & informative comments , i prepared him for bone marrow biopsy

**Mona Mansour** Is MAS a possible d.d in the presence of leukocytosis?

**Omer Mala Ahmed** Thanks dear prof **Mona Mansour** , yes MAS is one of the possibilities but MAS associated also with elevation of liver enzymes & usually respond to high doses of steroids unlike our case which is not associated with elevated liver enzymes & not responded to pulses of Steroids

**Omer Mala Ahmed** Dear profs & Doctors

**Howaida Elsayed Mansour**, **Basant Esawy**, **Mona Mansour**, **Amal El Ganzoury**, **Aliaa Omar El-hady**, ....

Today we arranged for the little poor boy BM Biopsy & unfortunately the result returned as Leukemia of ALL Subtype  
What I learned from this case are :

- Normal CBC & Blood film doesn't exclude Leukemia.
- Leukemia may occur without hepatosplenomegaly !
- although I sent the child one month ago to BM biopsy but the prof of Hematology said this case not in need of BM biopsy because the CBC & Blood films not going with Leukemia!
- when ever you see thrombocytopenia means the case is not sJIA & it indicates either Leukemia &/or MAS which both of them can only be diagnosed by BM biopsy.

THANKS AGAIN FOR ALL YOUR HELPS

**Aliaa Omar El-hady**

Depressive case لا اله الا الله...شفاه الله وعافاه...

**Howaida Elsayed Mansour** That is what I was afraid of....since the 1st time I read this case ..-as you know dr.**Omer Mala Ahmed**



Since early beginning I felt uncomfortable to diagnose sJIA :

1- The presence of early thrombocytopenia less than 180,000

2- The boy is very young he is just 2 years old with only mild knee arthritis

3- Leukemias is the 1st DD of sJIA and should be ruled out..

4- LL arthritis is very common in leukemias ...specially ALL

5- Severe loss of weight and loss of appetite but in stills disease in between the attacks of fever the appetite is ok...etc

6- if you suspect something follow your clinical since - even if the others disagree...

**Omer Mala Ahmed** Thanks Dear Great prof **Howaida Elsayed Mansour** for your always amazing clinical points, yes on the first presentation you said this case need BM Biopsy & you suspended Leukemia, I learned too much from your golden advices

And at the same time I sent the case for BM Biopsy but unfortunately the hematologist mislead me & the parents & said exactly this is not a case of Hematological malignancy & not in need for this invasive unnecessary procedure

**Basant Esawy** This is the usual behavior of hematologist usually they keep insisting no hematologic malignancy , this is due to autoimmune disease , do not worry we all suffer from them

**Omer Mala Ahmed** Thanks prof **Basant Esawy** for your valuable comments ☐ ☐

**Omer Mala Ahmed** The result of BM biopsy

Kurdistan Region Government  
Ministry Of Health  
Pediatric Hospital  
Hematology Department

*Bone Marrow Report*

نێمهێتی هه‌ڕه‌ی کوردستان  
هه‌زاره‌تی نه‌نه‌دووسه‌تی  
هه‌خوێشه‌خانه‌ی مه‌ڵاڵان  
ناوچه‌ی هه‌ماتۆلۆجی

Name: *نێو مه‌حمه‌د عه‌د العاکهر* Age: 3 years Sex: male

Clinical Note: Pallor

Date of Aspiration: 31. January. 2016

Hypercellular trail of marrow specimen though no fragments of marrow are seen.

There is heavy infiltration by blast cells( more than 70% of cells) which are of lymphoblastic types , homogeneous most of them are of small size with condensed chromatin with no or inconspicuous nucleoli, regular nuclear membrane.

There is marked reduction in all other hemopoietic elements, the erythroid, myeloid and megakaryopoietic cells.

**Conclusion:** Acute lymphoblastic leukaemia (ALL / L1 )  
According to FAB classification of acute leukaemia

*Ali*  
Signature  
Dr. Ali Ibrahim Mohamad  
The hematopathologist  
MBChB FICMSpath

2/February /2016

Sherry Kamel unfortunately , leukemia as dr. Howida suspect from beginning ,,,

**Dalia Hussien Kamel**

January 30 at 4:39pm

55years old female pt. Sclerodactyly. Z\_shaped deformity of both thumbs, swan neck in index, dysphagea, bowel symptoms(diarrhea, constipation.)

\*RF\_ve

\*ANA\_ve

\*anti RNP\_ve

\*Hb10.5

\*TLC5.9

\*platlets272

\*s. Creat. 0.8

\*bl urea66. Nomal:15:45

\*BUN 30.8. Normal:7:21

\*liver function & stool&urine analysis :normal

Complaints started 5years ago & she treated with methotrexate for ayear or more

Xray chest showed mild bilateral interstitial reaction, associated e accentuated brochovascular markings

What about diagnosis&treatment



**محمد عبد الفتاح** What about esr, crp. Is this deformity flexible or fixed. What about X Ray both hands. Is there joint destruction.

محمد عبد الفتاح Is the patient hepatic b or c

Dalia Hussien Kamel The pt isn't hepatic. At DIP the flexion deformity can be corrected but at PIP the joints are fixed. The xray of hands was done 5yrs ago it shows deformity but no erosions

Dalia Hussien Kamel I should ask for new x ray?

Dalia Hussien Kamel Nooran Nooran

محمد عبد الفتاح Is there morning stiffness or swelling

محمد عبد الفتاح I don't notice any MCP swelling

محمد عبد الفتاح Is there any muscle imbalance

Dalia Hussien Kamel She can't flex her fingers at all so MS not present

محمد عبد الفتاح What about sensory exam

محمد عبد الفتاح No complaint at all about morning swelling

محمد عبد الفتاح I think this pt needs new X Ray and CRP 1st to assess

Dalia Hussien Kamel Sensory exam why?

محمد عبد الفتاح If all investigation including ESR, CRP, hand X Ray is normal, and no swelling or any moderate joint affection. You should also think about muscle imbalance or paradoxical rheumatism. But in the later case, there is high ESR

محمد عبد الفتاح

لو ظهرت الأشعة وسرعة الترسيب يا ريت تشركيني مع حضرتك فيها

Howaida Elsayed Mansour Dear dr. Dalia Hussien

Kamel what about the history is there arthralgia or arthritis ?? which joints ?? Is there any morning stiffness? ? Is there any Raynaud's phenomenon all these questions are very important points to reach the correct diagnosis... Where is the CBD and the ESR, CRP and prot/creat ratio plain x ray hands all are essentials to me this is not scleroderma case it is either RA or OA...

Aliaa Omar El-hady Try to repeat ANA & anti-RNP in another famous lab. do ESR, CRP, new hand radiology... may be overlap syndrome or MCTD.... any RP??

DrSharad Kedia What about all these being the extra articular manifestations of IBD

**Howaida Elsayed Mansour** No dear bec that time the history will be completely different there would be chronic bloody diarrhea and abdominal pains / mal absorption syndrome. ...etc in medicine we diagnose our patients mainly from the history and next from the general examination and finally from the local MSK examination. ..and accordingly we will ask for investigations. ..

المشكلة ياد علياء عشان اطلب منها تعيد التحاليل دي مشكلة هي بالعافيه عملتهم بمجرد اني اتوصل لاشعه جديدة وباقي التحاليل هاعرضها علي حضراتكم وشكرا جزيلًا لاهتمامكم

**Aliaa Omar El-hady**

فيه عيانيين كثير بتعمل التحليل ده بيطلع سلبي او ايجابي وببيقي مش ماشي مع الحالة ولما باطلب اعاده بيطلع مختلف...فيه كثير من المستوصفات الكيتمس بتاعتهم expired

**Dalia Hussien Kamel** No raynauds phenomenon

**Dalia Hussien Kamel**

وحضرتك لما بتطلبي إعادة التحليل ببيكون علي حساب المريض ولا المعمل؟ لان المعامل بتطلب ارقام كبيره لاتتناسب حتي مع التكلفة وطبعا بنتعامل في مستشفيات الوزارة مع مرضي قدراتهم الماديه ضعيفه وباشفق عليهم جدا لما اطلب منهم حاجه Aliaa Omar El-hady مكلفه والمشكله ان شغلنا بيعتمد علي التحاليل بشكل كبير

**Aliaa Omar El-hady**

على حساب المريض

**Eiman Abd El Raoof F**

**Dalia Hussien Kamel**

الاولي هي الاشعة القديمة للمريضة من ٥ سنين والثانية هي الحديثة

**Dalia Hussien Kamel** I referred the pt to Sohag university &updates as the following

ESR 107

RF -ve

Accp. -ve

Anti smith anti. -ve



RNP(second time) -ve

ANA. -ve

On their examination there's beginning of raynauds in her toes

They asked for high resolution CT to detect whether the interstitial reaction detected in x ray inflammatory or due to fibrosis

**Dalia Hussien Kamel** Sorry for delay because invest. took long time

**Dalia Hussien Kamel**

Dr Aliaa Omar El-hady ،Prof .Howaida Elsayed Mansour  
د محمد عبد الفتاح.

محمد عبد الفتاح I think it's a case of service. I'd like to ask you about any lesions of psoriasis additionally to what u said before. I suggest treatment in form of salazopyrin, mtx, hydroquine with small dose of corticosteroids.

محمد عبد الفتاح Sero - ve raSee Translation

**Dalia Hussien Kamel** What's case of service mean?, No psoriasis, they suggest to be scleroderma  
محمد عبد الفتاح  
محمد عبد الفتاح I mean sero - ve. It's just a mistake in writing

**Aliaa Omar El-hady** I think with this high ESR you have to exclude malignancy

**Dalia Hussien Kamel** But what's the relation between malignancy&the deformity? Dr **Aliaa Omar El-hady**

**Howaida Elsayed Mansour** Dear dr **Dalia Hussien Kamel** dont waste more time this patient has bilatetal and symmetrical inflammatory arthritis with typical Rheumatoid like - pattern and deformities with very high ESR and CRP she has Rheumatoid arthritis subtype of adult onset stills disease ...this is completely different than sero -ve RA (here the ESR and CRP are very high much more than levels seen in sero -ve RA) this subset of disease show poor response to all traditional DMARDs , if you can pls do serum ferritin to confirm it would be high (but not very high

like that seen in systemic AOSD) and start ttt by pulse soluomedrol 1gm daily for 3 days followed by 600 mg Endoxan bec this subtype of RA is very resistant to ttt by traditional DMARDs..cyclic every month for 4-6 months (this is my experience in cases like your case, not evidence based) + oral hydroquine 200 1x2 + 20 mg oral steroids + calcium and vit D after 2 cycles start hand physiotherapy. ..

**محمد عبد الفتاح** I agree with you dear Dr howaida in the high esr situation but why u decided to give endoxan from the start. And what about triple therapy I said before.

**Howaida Elsayed Mansour** She already took MTX long time without any benefit, bec this subtype is very resistant to traditional DMARDs...

...

**Dalia Hussien Kamel** Thanks too much dr **Howaida Elsayed Mansour**

**Dalia Hussien Kamel**

February 4 at 6:17pm

48yrs female complainig of bilateral elbow synovitis e lag of extension of 3mnth duration&bilateral ankle synovitis&lt wrist,rt middle pip

Dry eye&mouth

No oral ulcers or hair fall

No malar rash

The pt is hypertensive &take concor

Investigation

RF 24

ESR 88

CRP 24

GPT 7

GOT 10

S. Creat. 1.3

TLC 5.8

Diagnosis RA?

scoreللjoints? تاخذ كام

**Dalia Hussien Kamel**



**Dalia Hussien Kamel**

د محمد عبد الفتاح

## Omer Mala Ahmed Definitive RA

●●●○ ASIACELL 2:03 PM 36%

< HOME ACR-EULAR criteria

**A. Joint involvement**  
(L: Large joints\*, S: Small Joints\*\*)

|    |       |      |       |     |
|----|-------|------|-------|-----|
| 1L | 2-10L | 1-3S | 4-10S | >10 |
|----|-------|------|-------|-----|

**B. Serology (R: RF, A: ACPA)**  
-: negative, +: Low-positive, ++: High-positive

|         |          |            |
|---------|----------|------------|
| R- & A- | R+ or A+ | R++ or A++ |
|---------|----------|------------|

**C. Acute-phase reactants**  
(C: CRP, E: ESR)

|              |                 |
|--------------|-----------------|
| Normal C & E | Abnormal C or E |
|--------------|-----------------|

**D. Duration of symptoms**

|          |          |
|----------|----------|
| <6 weeks | ≥6 weeks |
|----------|----------|

**Score 6/10 Definite RA**

\*Large joints: shoulders, elbows, hips, knees, ankles  
\*\*Small joints: metacarpophalangeal joints  
proximal interphalangeal joints  
2nd~5th metatarsophalangeal joints  
thumb interphalangeal joints, and wrists

**Ahmed Abdulbari** Ddx:

RA

Or

RA with secondary Sjogren

Or

Sjogren syndrome

Need extra work up

**Dalia Hussien Kamel** Dr Omer Mala Ahmed, the pt have 4large&2small joints so score 3???

**Dalia Hussien Kamel** Dr Ahmed Abdulbari she need what else?

**Dalia Hussien Kamel** X ray nomal?

**Ahmed Abdulbari** such as antinuclear antibody (ANA) and rheumatoid factor (because SS frequently occurs secondary to rheumatoid arthritis), which are associated with autoimmune diseases. Typical Sjögren's syndrome ANA patterns are SSA/Ro and SSB/La, of which SSB/La is far more specific; SSA/Ro is associated with numerous other autoimmune conditions, but are often present in Sjögren's. However, SSA and SSB tests are frequently not positive in Sjögren's syndrome.

The rose bengal test measures state and function of the lacrimal glands. This test involves placing the nontoxic dye rose bengal on the eyes. The dye's distinctive colour helps in determining the state and functioning of tear film and the rate of tear evaporation. Any distinctive colour change observed will be indicative of Sjögren's syndrome, but many related diagnostic tools will be used to confirm the condition of Sjögren's syndrome.[11]

Schirmer's test measures the production of tears: a strip of filter paper is held inside the lower eyelid for five minutes, and its wetness is then measured with a ruler. Producing less than 5 mm (0.20 in) of liquid is usually indicative of Sjögren's syndrome. This measurement analysis varies among patients depending on other eye-related conditions and medications they are on when the test is taken.[11] A slit-lamp examination can reveal dryness on the surface of the eye.

Symptoms of dry mouth and dryness in the oral cavity are caused by the reduced production of saliva from the salivary glands (parotid gland, submandibular gland, and sublingual gland). To check the status of salivary glands and the production of saliva, a salivary flow rate test is performed. Here, the patient is asked to spit as much as he or she can into a cup, and the resulting saliva sample is collected and weighed. This test's results can determine whether the salivary glands are functioning adequately. Not enough saliva produced could mean the patient has Sjögren's syndrome.[11] An alternative test is



nonstimulated whole saliva flow collection, in which the patient spits into a test tube every minute for 15 minutes. A resultant collection of less than 1.5 ml (0.053 imp fl oz; 0.051 US fl oz) is considered a positive result.[12]

A lip/salivary gland biopsy can reveal lymphocytes clustered around salivary glands, and damage to these glands due to inflammation. This test involves removing a sample of tissue from the patient's inner lip/salivary gland and examining it under a microscope. In addition, a sialogram, a special X-ray test, is performed to see if any blockage is present in the salivary gland ducts (i.e. parotid duct) and the amount of saliva that flows into the mouth.[11]

Also, a radiological procedure is available which is a reliable and accurate test for Sjögren's syndrome. A contrast agent is injected into the parotid duct, which opens from the cheek into the vestibule of the mouth opposite the neck of the upper second molar tooth. Histopathology studies should show focal lymphocytic sialadenitis. Objective evidence of salivary gland involvement is tested through ultrasound examinations, the level of unstimulated whole salivary flow, a parotid sialography or salivary scintigraphy. Autoantibodies against Ro (SSA) and/or La (SSB) antigens are also expected.

**Omer Mala Ahmed** Dear Dr Dalia **Dalia Hussien Kamel** in RA the small joints more significant than large joints so in the presence of small joints involvement we calculate the small joints in the equations & we neglect the large joints; so we use 1-3 small joints instead of 2-10 large joints.  
So the case is Definitive RA with Sicca Symptoms ( secondary Sjögren's syndrome)

## Case55

**Dalia Hussien Kamel**

February 9 at 5:27pm

67yrs old female pt, bilateral wrist synovitis, swan neck deformity in rt index. & lt middle fingers

No Rh nodules

ESR 17

RF\_ve

S. Creatinine 1.19

SGOT 10

SGPT 7

What about diagnosis? What about x\_ray?

2016/1/12

**Complete Blood count**

| Findings |                         | Normal      |         |        |
|----------|-------------------------|-------------|---------|--------|
|          |                         | male        | Female  |        |
| Hb       | 11.6 g/dl               | 14-16       | 12-16   | Ba     |
| PCV      | 34.8 l/l                | 48-52       | 36-46   | Segme  |
| RBCs     | 4.12 $\times 10^{12}/l$ | 4.5-6.3     | 4.2-5.4 | Eosino |
| MCV      | 80.6 fl                 | 77-91       |         | Basop  |
| MCH      | 27.7 pg                 | Htc 26-32   |         | Mono   |
| MCHC     | 33.3 g/dl               | 32-36       |         | Lymph  |
| Ret.     | %                       | < 2         |         | Metamy |
| Plt      | 266 $\times 10^9/l$     | 140-440     |         | Myeloc |
| WBCs     | 7200 $\times 10^9/l$    | 4 - 10      |         | Promyl |
| NRBCs    | /100WBCs                | 00/ 100WBCs |         | Blast  |
|          |                         |             |         | At L   |



**محمد عبد الفتاح** I see in X Ray, amalgamation in wrist, radil erosion in 2nd, 3rd, 4th pip and asymmetric narrow pip joints. Also, osteophytes in dip joints. If the case had taken corticosteroids and dmards before so esr is low or suspect erosive osteoarthritic changes. Also need to know if your patient hepatic virus or not.

**Dalia Hussien Kamel** The pt is diagnosed by orthopedic drs as rhematoid arthritis & received ttt in strange manner :mtx tab(one tab)every other day&Diprocortin vial every month for 2yrs or more

**Dalia Hussien Kamel** How can i reach the correct diagnosis now?

**Omer Mala Ahmed** Thanks for sharing this case dear dr **Dalia Hussien Kamel**

Your case is Surely Nodal OA of Hands , no need further investigations.

We see Gull-Wing signs of Nodal OA in DIP joints which are

specific for Nodal OA.

Regarding the Osteoarthritis of the Wrists they can be idiopathic, but it is mostly seen as a post-traumatic condition, so surely the patient had history of falling on hands .

There are different types of post-traumatic Wrist osteoarthritis.

- Scapholunate Advanced Collapse (SLAC) is the most common form.( i see evidence of SLAC in the films of your case )

- Scaphoid Non-union Advanced Collapse (SNAC).

- Other post-traumatic causes such as intra-articular fractures of the distal radius or ulna can also lead to wrist osteoarthritis, but are less com

**Dalia Hussien Kamel** Thanks dr. Omer Mala,so u see she has erosive OA?&what about ttt?hydroxychloroquine?

**Omer Mala Ahmed** Yes NSAIDS + Glucosamine & Chondroitin + HCQ

**محمد عبد الفتاح** Agree with you. As I said before I see erosive osteoarthritic changes. But also to exclude any other causes should be accp and hepatitis b, c done.

**Howaida Elsayed Mansour** The picture of the patients hands is very important. ..

**Omer Mala Ahmed** Exactly prof **Howaida Elsayed Mansour** we always need the pictures of the affected organs in addition to the imaging pictures

**Howaida Elsayed Mansour** Likely she has nodular Osteoarthritis, but take care bec your patient is severely osteoporotic DEXA scan and antiosteoporotic ttt are highly recommended in this age ...

**Mona Mansour** Hcq can be useful in cases with hand OA erosive form

**Dalia Hussien Kamel** Thanks alot dears drs, Omer Mala Ahmed, Howaida Elsayed Mansour&**محمد عبد الفتاح** I'll share e u picture of her hands as soon as I have.&Iasked her for anti CCp but she dout that she can do because she hardly can leave her home&I'll advice her to do DEXA.Thanks alot

## Case56

**Omer Mala Ahmed**

February 7 at 10:05pm

♻️Acromegaly:







**Aliaa Omar El-hady** thank you for sharing

**Case57**

Aliaa Omar El-hady

January 25 at 7:00am

حالة عرضتها صديقة لنا ... ارجو الاهتمام بها

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الحاله ده ي فندم .. بتشتكي من تنميل و وألم فظيع وتقل ف ايدها .. مبتعرفش تعمل  
بيها حاجه  
عملت دوبلر لقيت في جلطتين ف الدراع الشمال.....وحاليا في ألم ف الدراع اليمين  
في احمرار ف الجبهه و psoriasis ف كذا حته ف جسمها و سقوط ف الشعر جامد  
وبتشتكي بأنها بتتسي كثير جداا بطريقه مستفزه.....ودي كل التحاليل اللي عملتها  
ماشيه حاليا علي melga و aspocid و vit B12 مره ف الأسبوع وباندول بتاع  
ال joints  
ومفيش تحسن بالعلاج نهائي  
اديلها شهر  
وفي رضاعه ي دكتور

-----  
الملخص  
-----

Recurrent thrombophlebitis of cephalic vein + high cardiolipin  
+ defeciency in protein C + hypochromic microcytosis  
anisocytosis + leucopenia + neutropenia + ANCA cytoplasmic  
+ve

وبترضع وماشية على اسبرين؟؟؟  
ياريت تناقشوها وتتعالج بايه وتتابع ازاى؟؟

LABORATORIES

الطبيب المعالج: أ.د. محمد نبيل  
تاريخ الحضور: 2015/12/09 15:01  
تاريخ التقرير: 2015/12/17

إسم المريض : مدام  
رقم المريض : 57.5124  
ضحي احمد ابو الخير محمد

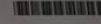


|                                | <u>Patient Report</u>  | <u>Ref. Range</u> |
|--------------------------------|------------------------|-------------------|
|                                | <u>Immunology Unit</u> |                   |
| C-Reactive Protein (CRP) Titre | 1.77 mg/L              | -Up to 5.0        |
| HCV Antibody 3rd Generation    | Negative               | Negative          |

LABORATORIES

الطبيب المعالج: أ.د. محمد نبيل  
تاريخ الحضور: 2015/12/09 15:01  
تاريخ التقرير: 2015/12/17

إسم المريض : مدام  
رقم المريض : 57.5124  
ضحي احمد ابو الخير محمد



|                                       | <u>Patient Report</u> | <u>Ref. Range</u>    |
|---------------------------------------|-----------------------|----------------------|
| Anti Nuclear Ab Titre (ANA/Hep-2).    |                       |                      |
| Titer                                 | Neg. less than 1/40   | -Up to 1/40 Negative |
| Pattern                               |                       |                      |
| ANCA (Titer)                          |                       |                      |
| Perinuclear                           | Neg. less than 1/20   | Less than - 1/20     |
| Atypical Perinuclear                  | Neg. less than 1/20   | Less than - 1/20     |
| Cytoplasmic                           | Positive 1/20         | Less than - 1/20     |
| Anti DNA (Anti-ds-DNA,) by IF (titer) | Neg. less than 1/10   | Up to 1/10           |
| Result                                |                       |                      |

| TEST NAME | RESULT | UNIT | BIOLOGICAL REFERENCE INTERVALS |
|-----------|--------|------|--------------------------------|
|-----------|--------|------|--------------------------------|

## Hematology

### Complete Blood Picture

|                        |        |               |             |
|------------------------|--------|---------------|-------------|
| Haemoglobin            | 11.6   | g/dl          | 11.5 - 15.5 |
| Haematocrit (PCV)      | 39.3   | %             | 36 - 45     |
| RBCs Count             | H 5.66 | millions/cmm  | 4.0 - 5.2   |
| MCV                    | L 69.4 | fl            | 80 - 100    |
| MCH                    | L 20.5 | pg            | 27 - 33     |
| MCHC                   | L 29.5 | g/dl          | 31 - 37     |
| RDW-CV                 | H 18.4 | %             | 11.5 - 15   |
| Platelet Count         | 398    | thousands/cmm | 150 - 450   |
| Total Leucocytic Count | L 3.9  | thousands/cmm | 4 - 11      |

#### Percent Values

#### Absolute Values

#### Differential Leucocytic Count

|             |      |   |      |                 |            |
|-------------|------|---|------|-----------------|------------|
| Neutrophils | 47.0 | % | 1.85 | $\times 10^9/L$ | 2 - 7      |
| Lymphocytes | 41.5 | % | 1.63 | $\times 10^9/L$ | 1 - 4.8    |
| Monocytes   | 9.7  | % | 0.38 | $\times 10^9/L$ | 0.2 - 1    |
| Eosinophils | 1.3  | % | 0.05 | $\times 10^9/L$ | 0.1 - 0.45 |
| Basophils   | 0.5  | % | 0.02 | $\times 10^9/L$ | 0 - 0.1    |

#### Other Cells

#### Comment :

RBCs SHOW HYPOCHROMIA, MICROCYTOSIS AND ANISOCYTOSIS MILD  
LEUCOPENIA ABSOLUTE NEUTROPENIA  
FOLLOW UP IS RECOMMENDED

## LABORATORIES

الطبيب المعالج: أ.د. محمد نبيل

تاريخ الحضور: 15/01 2015/12/09

تاريخ التقرير: 2015/12/10

إسم المريض : مدام ضحى احمد ابو الخير محمد

رقم المريض : 57.5124



#### Patient Report

#### Hematology Unit

#### Ref. Range

### Erythrocyte Sedimentation Rate (E.S.R)

12 mm

7 - 18

First Hour :

Comments : second hour : 35

| HEMATOLOGY REPORT                   |        |      |                                |
|-------------------------------------|--------|------|--------------------------------|
| TEST NAME                           | RESULT | UNIT | BIOLOGICAL REFERENCE INTERVALS |
| Hematology                          |        |      |                                |
| Anti-thrombin III (AT-III) activity | 92     | %    | 80 - 120                       |
| Coagulation Profile                 |        |      |                                |
| Prothrombin Time (PT)               |        |      |                                |
| Patient Prothrombin Time            | 13.5   | sec  |                                |
| Control Prothrombin Time            | 13.5   | sec  |                                |
| Prothrombin Concentration           | 100.0  | %    | 70 - 120                       |
| INR                                 | 1.00   |      |                                |
| PTT                                 | 24.3   | sec  | 23 - 40                        |
| Protein C Assay                     | L 59.0 | %    | 72 - 160                       |
| Free Protein S Assay                | 79.0   | %    | 60 - 150                       |

|                                           |                                  |
|-------------------------------------------|----------------------------------|
| Patient Name: : مدام / ضحى احمد ابو الخير | Registered : 02-12-2015 20:29    |
| Age / Sex : 27 Years/ FEMALE              | Collected : 02/12/2015 20:30     |
| Referred By : Prof.Dr. اسامة سعيد امام    | Authenticated : 04/12/2015 17:59 |
| Client Name : 8002                        | Reported : 05-12-2015 19:02      |

| TEST NAME                   | RESULT       | UNIT    | BIOLOGICAL REFERENCE INTERVALS |
|-----------------------------|--------------|---------|--------------------------------|
| Anti Cardiolipin Antibodies |              |         |                                |
| Anti-Cardiolipin IgM        | Positive 9.6 | MPLU/ml | Up to 6.9                      |
| Anti-Cardiolipin IgG        | Positive 17  | GPLU/ml | Up to 9.9                      |



اسم المريض : مدام منجي احمد ابو الخير محمد  
رقم المريض : 57.5124

اسم  
رقم

الطبيب المعالج: أ.د محمد نبيل  
تاريخ الحضور: 2015/12/09  
تاريخ التقرير: 2015/12/17

alfa  
LABORATORIES

|                        | <u>Patient Report</u><br><u>Chemistry Unit</u> | <u>Ref. Range</u> |
|------------------------|------------------------------------------------|-------------------|
| SGPT (ALT)             | 11 U/L                                         | Up to 35          |
| SGOT (AST)             | 13 U/L                                         | Up to 35          |
| Serum Urea             | 16 mg/dL                                       | 17 - 43           |
| Serum Creatinine       | 0.8 mg/dL                                      | 0.66 - 1.09       |
| Serum Calcium (Total). | 9.0 mg/dL                                      | 8.6 - 10.2        |

اسم المريض : مدام منجي احمد ابو الخير محمد  
رقم المريض : 57.5124

الطبيب المعالج: أ.د محمد نبيل  
تاريخ الحضور: 2015/12/09  
تاريخ التقرير: 2015/12/15

alfa  
LABORATORIES

|                                    | <u>Patient Report</u><br><u>Immunology Unit</u> | <u>Ref. Range</u> |
|------------------------------------|-------------------------------------------------|-------------------|
| Sacchromyces Cerevisiae ABS (ASCA) |                                                 |                   |
| S. Cerevisiae IgA                  | 2 U/mL                                          | - Up to 10        |
| S. Cerevisiae IgG                  | 1.5 U/mL                                        | - Up to 10        |

**alfa**  
LABORATORIES

الطبيب المعالج: أ.د محمد نبيل  
تاريخ الحضور: 15:01 2015/12/09  
تاريخ التقرير: 2015/12/17

إسم المريض : مدام ضحي احمد ابو الخير محمد  
رقم المريض : 57.5124

**Patient Report**

| Test Name                          | Result | Unit | Ref. Range                                              |
|------------------------------------|--------|------|---------------------------------------------------------|
| Beta-2-Glycoprotein Abs(IgG & IgM) |        |      |                                                         |
| Beta-2-Glycoprotein Abs(IgG)       | 2.3    | U/mL | - Up to 5 Negative<br>5-8 Borderline<br>Over 8 Positive |
| Beta-2-Glycoprotein Abs(IgM)       | 3.7    | U/mL | - Up to 5<br>5-8 Borderline<br>Over 8 positive          |

Patient Name: مدام / ضحي احمد ابو الخير  
Age / Sex : 27 Years / FEMALE  
Referred By : Prof.Dr. اسامة سعيد امام  
Client Name : 8002

Registered : 02-12-2015 20:29  
Collected : 02/12/2015 20:30  
Authenticated : 04/12/2015 17:59  
Reported : 05-12-2015 19:02

| TEST NAME                   | RESULT       | UNIT    | BIOLOGICAL REFERENCE INTERVALS |
|-----------------------------|--------------|---------|--------------------------------|
| Anti Cardiolipin Antibodies |              |         |                                |
| Anti-Cardiolipin IgM        | Positive 9.6 | MPLU/ml | Up to 6.9                      |
| Anti-Cardiolipin IgG        | Positive 17  | GPLU/ml | Up to 9.9                      |

**Aliaa Omar El-hady** Profs & Drs. **Bassel El-Zorkany** - **Geilan Ibrahim** - **Amal El Ganzoury** - **Basant Esawy** - **Omer Mala Ahmed** - **Sherry Kamel** - **Mohammed Hassan** - **Tamer Elfarahaty** - **Rageh M. Elsayed** - **Howaida Elsayed Mansour** - **Mona Mansour** - **Mohamed Magdy** - **Aliaa Omar El-hady** **Samar Hussien Huzien** **Enas Farid**

علشان نتابع البوست ونسيب الكومنتات turn on notifications من فضلكم نعمل  
لمناقشة الحالة

**Amal El Ganzoury** dear Dr Aliaa and colleagues for such multidisciplinary case .

just I am wondering if we have all this suggested diagnosis psoriasis 1ry phospholipid and deficiency of protein c. Any how the definite findings are recurrent thrombophlebitis in presence of high Anti cardiolipin antibodies suggest 1ry phospholipid syndrome .she should take aspirin ,warfarin adjust dose so INR is between 2 and 3.

for ANCA Positivity we should measure MPO and proteinase 3 by Elisa. level may really reflect if there is vasculitis or not especially markers of inflammation are low.

lupus should be fully assessed ANA double strands DNA. Anti smith.

C3 and c4. if fulfilling criteria hydroxychloroquine should be added

for psoriasis should be assessed by dermatologist to assure

**Aliaa Omar El-hady** thank a lot dear prof.

**Ahmed Fahmy** So SLE is more reliable diagnosis if we search for

And if the patient not fulfill the criteria could we consider this case as psoriasis and 1ry APL syndrome? Dr **Amal El Ganzoury**

**Dina Mahmoud** F

**Geilan Ibrahim** A nice case however i want to be sure if the patient has dvt or only thrombophlebitis

The diagnosis of psoriasis is confirmed or it may be some things like scler

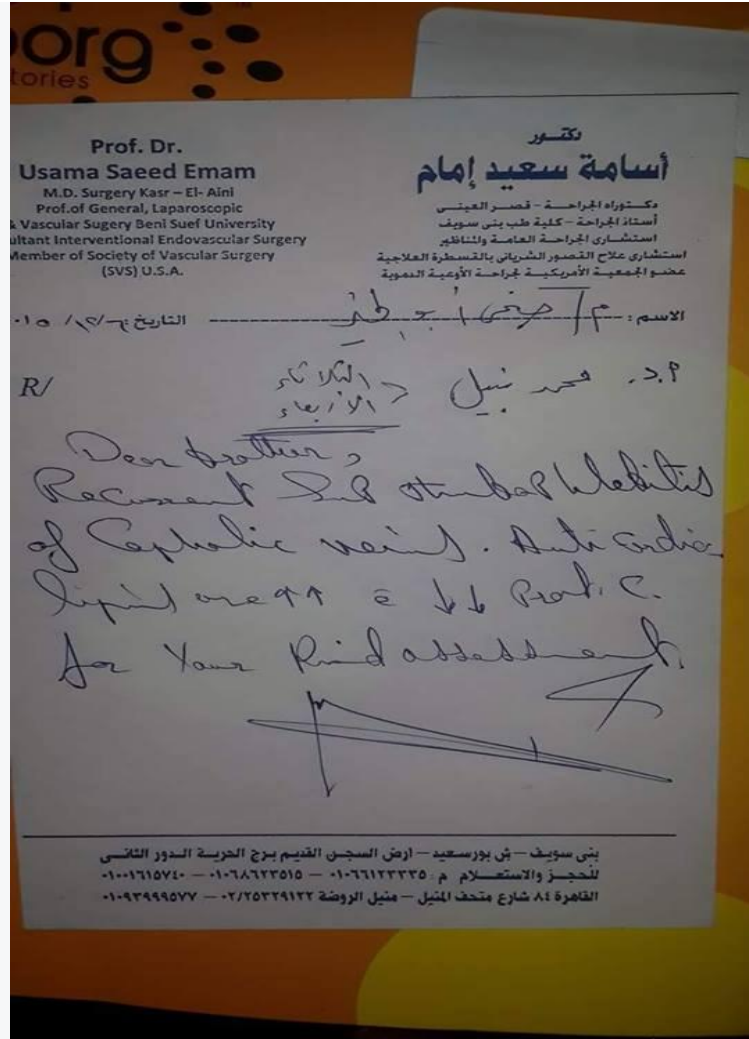
Urine analysis is recommended

Disease duration

Recent signs on examination

**Aliaa Omar El-hady**

thrombophlebitis of cephalic veins  
حضرتك دكتورها باعتها انها



## Geilan Ibrahim

العيانه مع حضرتك

## Aliaa Omar El-hady

لا يا افندم... بعتلى المعلومات بتاعتها طبيب مقيم بنى سويف طالبة المشورة

## Aliaa Omar El-hady

جزاك الله خيرا استاذتنا على افادتنا بالحالة ... الى حضرتك طلبتيه سيتم استكمالها ان  
 Prof. Geilan Ibrahim شاء الله ... حابلغها به

## Geilan Ibrahim

خليه يتواصل معانا

## Aliaa Omar El-hady

انا ممنشناها والله ...

## Aliaa Omar El-hady

| LABORATORY                            |                     | اسم المريض : د. منى احمد ابو الخير محمد |          |
|---------------------------------------|---------------------|-----------------------------------------|----------|
| الطبيب المعالج: د. محمد نبيل          |                     | رقم المريض : 57 5124                    |          |
| تاريخ الحضور: 15/01 2015/12/09        |                     |                                         |          |
| تاريخ التقرير: 2015/12/17             |                     |                                         |          |
|                                       | Patient Report      | Ref. Range                              |          |
| Anti Nuclear Ab Titre (ANA/Hep-2).    |                     |                                         |          |
| Titer                                 | Neg. less than 1/40 | - Up to 1/40                            | Negative |
| Pattern                               |                     |                                         |          |
| ANCA (Titer)                          |                     |                                         |          |
| Perinuclear                           | Neg. less than 1/20 | Less than - 1/20                        |          |
| Atypical Perinuclear                  | Neg. less than 1/20 | Less than - 1/20                        |          |
| Cytoplasmic                           | Positive 1/20       | Less than - 1/20                        |          |
| Anti DNA (Anti-ds-DNA,) by IF (titer) | Neg. less than 1/10 | Up to 1/10                              |          |
| Result                                |                     |                                         |          |

Aliaa Omar El-hady ANA <1/40

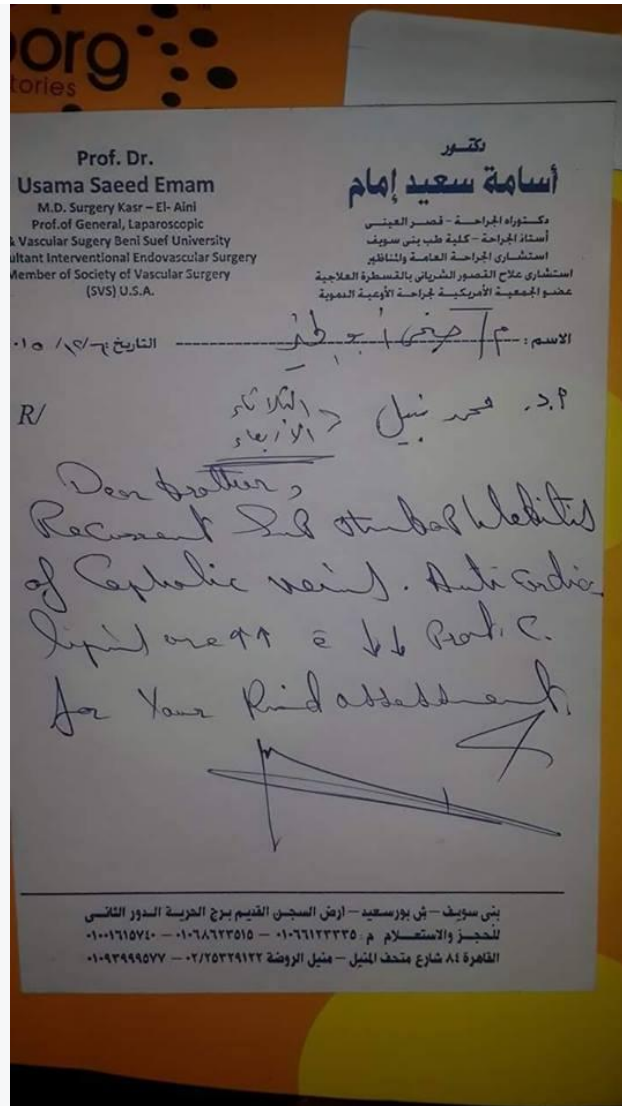
Sherry Kamel

صباح الخير ....ياريت لو سمحتوا اللي يعرض حاله يحاول يشيل اسم المريضه ،واسم الطبيب المعالج ،لان الطبيب المعالج كما هو واضح ا.د. محمد نبيل ..زميل وخصوصا ان ممكن his clinical approach عزيز ومن الاحراج اننا نعلق علي ولم تكون المريضه مارجعتش بالتحاليل دي ليه او بتاخذ تذكر هذا..فخرجوا رفعوا للخرج محاوله حجب اسم الطبيب والمريض ....

Aliaa Omar El-hady

حضرتك ادى الريكويست اللي رايح به





**Aliaa Omar El-hady**

واتحالت على الروماتيزم

**Sherry Kamel**

انا مش معترضه علي الريكوست ، انا بقول نحاول يا دكتور نحجب اسم الدكتور

**Aliaa Omar El-hady**

انا عرضتها زى ما هى بعنتها لى من بنى سويف ... ان شاء الله المرات القادمة ...  
المهم رأيك فى الحالة لافادة المريضة

**Sherry Kamel**

oral ... اتفق تماما مع راي د. امل الجنزوري لابد من اعطاء المريضة  
anticoagulant

**Hany Aly**

انا متفق مع حضرتك د. شيرى.  
يفضل حجب اسم المريض والطبيب.

case report اذكر انى عرضت فى ايام نيابتى حالة  
(ذكرت اسم المريضة وتم تعينى تعين شديداً من احد الاساتذة).

**Sherry Kamel**

hyper coagulable state 1ry APL and protien c deficiency الحالة  
,we have to rule out any cause of secondary Abs

**Sherry Kamel** Also the skin lesion may be not psoriasis but  
type of sub acute cutaneous lupus as Dr.Gelian said

**Omer Mala Ahmed** Thanks for sharing this interesting case dr  
Aliaa Omar El-hady.

To me this case still has clinical criteria for SLE despite  
negative ANA, plus secondary APL syndrome.

□ □ The psoriatic skin lesions may be the Psoriasiform pattern of  
SACL .

□ □ the redness over the forehead may be Discoid skin lesion or  
Photosensitive skin lesions, this are is most common site for  
these skin lesions.

□ □ the lost memory may be dueto Neuropsychiatric lupus as  
you know patients with SLE may demonstrate many psychiatric  
disorders including significant cognitive defects, such as  
attention deficit, poor concentration, impaired memory.

Although the findings are not specific but still we need to  
arrange for CSF analysis as elevated levels of proteins & cells  
are seen in 1/ 3 of cases , also we need to arrange for MRI of  
brain to find any evidence of Neuropsychiatric lesions or  
evidence of micro thrombi secondary to APL syndrome, also  
she need Psychiatric consultation .

□ □ This case also in need of Anti-Ro , GUE , Urine for Pr/Cr  
ratio & Complement assay .

□ □ ANCA could be positive in SLE patients & has no  
significance in the absence of Clinical signs of ANCA  
associated vasculitis .

Regarding Management of this case ; she in need of :

1-HCQ for both Lupus manifestations( skin lesions, hair fall ....)  
& also helps in decreasing the thrombotic events .

2- Anti Coagulation with warfarin to keep the INR between 2-3 .

3- because of arterial thrombosis we should also add anti-

platelet drug Aspirin 100mg/ day in addition to warfarin because it was found that Platelets are contributed in Artrial thrombosis although combination of Aspirin & Wrfarin may increase the risk of bleeding.

4- we may in need to add other drugs like Cyclophosphamide if we confirmed the Neuropsychiatric lupus after arranging the above tests & Psychiatric consultation .

To me she has psychiatric manifestations of SLE & she in need of 6 pulses of Cyclophosphamide followed by AZA in addition to psychiatric drugs

5- we should also find if there is evidence of nephritis or not ?  
Latter we arrange the treatment for it .

[Aliaa Omar El-hady](#)

جزاك الله خيرا ... تحليل ممتاز

[Hany Aly](#) Thanks alot. Dr. Omar.

[Aliaa Omar El-hady](#) Prof. [Howaida Elsayed Mansour](#)

[Aliaa Omar El-hady](#) [Samar Hussien Huzien](#)

[Basant Esawy](#) Totally agree with dr [Amal El Ganzoury](#)

Mostly primary APS

Protein c usually low during thrombotic events so should be repeated at least 2 w after the thrombotic attacks

Positive ANA could give falsely positive ANCA plus not all positive ANCA is considered ANCA vasculitis that's why you should measure MPO and proteinase 3 tiers especially no s&s suggestive of ANCA vasculitis except neuropathy and normal ESR

Regarding Sle , repeat ANA and the psoriatic skin lesions if debatable by dermatologist should be biopsied

Memory impairment can occurs with APS as a part of micro embolism or shower of emboli of cardiac vegetation

So transeosophageal ECHO is mandatory in such case

For me unlikely SLE with normal ESR and negative ANA and in case of memory loss in cases of Sle treated as low dose steroids and HCQ as if no infractions and only lacunae lesions which also can be justified with aCL antibodies

So diagnosis

APS for aspirin and warfarin

Before starting anticoagulant repeat C3 and do circulating lupus anticoagulant

TEE

[Aliaa Omar El-hady](#)

[Basant Esawy](#) جزاك الله خيرا استاذتنا على الاهتمام بالحالة

[Basant Esawy](#)

جزاك الله خيرا مشاركتنا الحالات واهتمامك بالمريض

[Aliaa Omar El-hady](#)

[Howaida Elsayed Mansour](#) I agree with you dear dr [Basant Esawy](#) except in postponing the anticoagulation till doing LA and C3 ...anti coagulation should be started immediately as this is a very serious situation with recurrent thrombotic events

[Basant Esawy](#) I did not postpone dear dr [Howaida Elsayed Mansour](#)

My point is the sample should be taken first before starting as ptn c,s and lupus anticoagulant as results unreliable after starting warfarin

..

[Marwa Aldosoky](#) [Marwa EL-Sayad](#)

[Mohammed Hassan](#) nice and difficult case dr Aliaa ... what about photosensitivity, oral and genital ulcerations, i want to confirm if skin lesion is really psoriasis or other lesion as psoriasiform SCLE ? . this case has thromboembolic , skin , neuropsychiatric and haematological problems . i want to continue inv plz ANA, anti Ro, anti dsDNA, c3, urine analysis, 24h prturia, csf analysis ..... for me i think it'll be SLE with 2ndry APS .... i suggest stop lactation and give HCQ 400mg/d, AZA 150mg/d, warfarin and keep INR 2.5:3 , low dose aspirine, Vit D 1ug/d . then re- evaluation again after continue the inv and confirm the diagnosis for further ttt protocols [Aliaa Omar El-hady](#)

[Aliaa Omar El-hady](#) °ANA < 1/40, DNA <1/10

[Aliaa Omar El-hady](#)

Dr. [Mohammed Hassan](#) جزاكم الله خيرا ونفع بعلمكم

**Mona Mansour** Thanks for our colleagues for their input on this case of APS the issue is wheather it is primary or secondary, in addition to the requested investigations that Dr.

Amal.elganzoury, Dr Howaida El Sayed Mansour, and Dr Omer Mala Ahmed added, I would like to request for skin biopsy and dermatological consultation and at the same time to start the medications in form of antithrombotic therapy and if it is proved to be Lupus treat with remission inducing drugs if there is renal or other majour organ affection.

**Aliaa Omar El-hady**

Prof. **Mona Mansour** جزاكم الله خيرا لاهتمامكم بالرد وبالرأى السديد ... نفع الله بعلمكم

**Rageh M. Elsayed** Dear all good pm thanks dr **Aliaa Omar El-hady** for nice case for me this case is 1ry APS work up to exclude SLE as our prof mentioned befor we need 1- good dermatologist to clarify nature of skin lesion 2- neurological manifestation may with 1ry APS although non diagnostic criteria 3- totally agree as the pt has thrombotic event we must keep INR 2-3 the patient has only 1 4- with above mentioned ttt we need to add omega 3 thanks good luck

**Aliaa Omar El-hady**

Prof. **Rageh M. Elsayed** جزاكم الله خيرا ونفع بعلمكم

**Howaida Elsayed Mansour** Dear all, dear dr Aliaa Omar El-hady this patient has recrrtent upper arm thrombosis with extensive hair loss, Psoraitic like - skin rash +ve anti cardiolipin antibodies + ANCA , neutropenia but the ANA and DNA were negative please we need to do C3 and C4, prot/ creat ratio ; if the complement is consumed she is likely having "1ry APS in lupus transformation..." as 20 % of 1ry APS cases may transform to frank lupus with time .. Acc to the SLICC classification criteria: consumed complement could replace the ANA and DNA test and so do ACL antibodies... at the same time dermatologist consultation for the rash should be done as this rash may be variant of lupus rash (many are very similar to



psoriasis ) or if it is true psoriasis this would be just an association with lupus. Check for hypertension that should be tightly controlled. Until then, she should be kept on marivan 7 mg daily to keep the INR around around 2 , jusprin 81 mg + hydroquine 200 1x2 + 10 mg hostacortin H + Calcium + vit D + depovit IM once /week if prot/creat ratio or urine analysis shows active urinary sediments renal biopsy should be done...

**Aliaa Omar El-hady**

Prof. **Howaida Elsayed Mansour** جزاكم الله خيرا ونفع بعلمكم

**Mona Mansour** Dear Dr. **Howaida Elsayed Mansour** why do ot we start with parentral anti coagulation as warfarin interrupts the production of vitamin K–dependent coagulation factor production by the liver. The effect is delayed by 72 hours until the existing circulating coagulation factors are cleared or used. The initial effect creates a hypercoagulable state because vitamin K–dependent anticoagulants (protein C and S) are cleared first from the body while vitamin K–dependent procoagulants continue to circulate. During this period, heparin anticoagulation is important to prevent worsening thrombosis.

**Howaida Elsayed Mansour** I didnt get you ? if you need to start the anticoagulation parenteral in the 1st 3 days with warfarin totally agree. ..

**Mona Mansour** Yes I do, if there is no contraindications and the patient is admitted and we'll controlled.

...

**Mona Mansour** Dear Dr. Alia please ask the patient if she is recieving oral contraceptive and adjust the dietary intake of vit K rich food to a constant level to ease the adjustment of warfarin dose. Also consult a vascular surgeon and do an X ray for her as she may have also bilateral cervical rib which may be an additional factor for the recurrent upper limb thrombosis.

[Amal El Ganzoury](#) of course dr mona this is the regular routine start with low molecular heparin then continue with oral anticoagulant

[Aliaa Omar El-hady](#)

[Mohamed Nabil Salem](#) Dear all colleagues, Thanks a lot dr [Aliaa Omar El-hady](#),for this nice case ppt,this case was referred (as you postulated earlier),from prof dr Osama Saed, she presented with UK numbness ,arthralgia,&psoriatic lesions, I ordered all this panel of investigations,but didn't see results back, I totally agree with prof dr Howaida Elsayed Mansour as regards importance of anticoagulation ,wether with LMWH,therapeutic dose & Marevan or DTI Eg Rivaroxaban ,or Dabigatran,with possibility of latent lupus ,And following pt with C3,C4,Anti Ro,la,but currently,the pt is diagnosed as 1ry APS,with follow of by MPO by ELIZA,SPEP,A/C ratio, thanks all colleagues for valuable comments ,Thanks dr Aliaa for informing me with the orderd data .

[Mohamed Nabil Salem](#) Thanks a lot dr [Sherry Kamel](#),because you were the only one among all colleagues,to highlight an important ethical point of view,of removing the name of the patient &treating doctor, as we learned from our professors .

[Hany Aly](#)

[Samar Hussien Huzien](#) Sorry dr .. [Mohamed](#) .. It was my mistake .. This patient asked me as a close friend not a doctor .. and I consulted Dr. [Aliaa](#) since I was too young to diagnose such A case .. I really didn't notice that reports have your name sir .. I should crop name from reports .. I am proud that I was one of ur students one day .. Please accept my regrets dear doctor

[Aliaa Omar El-hady](#) Thanks Dr. [Mohamed Nabil Salem](#) for your follow up & sorry for our fault جزاك الله خيرا

[Howaida Elsayed Mansour](#)

دي بس اکتفينا بکلام very important ethical point کلنا طبعاً موافقین علی ال  
dear dr [Mohamed Nabil Salem](#) .الدکتورة شیري ...

[Mohamed Nabil Salem](#)

دطبعاً دكتورة هويدا حضرتك اساس كل الاخلاقيات و مصدر لكل الصفات الاصلية .

**Howaida Elsayed Mansour**

الله يكرمك يا د نبيل ويكرمكم جميعاً

**Omer Mala Ahmed** Dear profs & Doctors Great thanks for this nice & Valuable discussion:

But may I direct some questions to Prof **Howaida Elsayed Mansour**, **Amal El Ganzoury** & **Mona Mansour**....

1- although the lines of management are the same but why most of you diagnosed the case as 1ry APL syndrome with SLE transformation? Why we also not think about SLE with 2ndary APL Syndrome? ?

2- psychiatric manifestations of SLE have the same importance of Organic manifestations & it's written in books that when there is Neuropsychiatric features in SLE patients they need aggressive treatment with pulses of Cyclophosphamide , our patient has loss of memory which may be much problematic for the patient even from thrombotic events !

Why we should not pay attention for this life destroying manipulation?

Great Regards

**Mona Mansour** To me this case is primary APLS with ? Possibility of secondary APLS to be confirmed by further investigations. The urgent issue is to treat the thrombotic manifestation while investigating for the etiology and the whole spectrum of the disease. I agree with you if she proved to have serious neuropsychiatric manifestation this is one of vital organ affection which needs remission inducing drugs. Any way it is an interesting case which stimulated us for a valuable discussion that I hope to have an impact on the diagnosis and treatment of this case.

**Aliaa Omar El-hady**

والله دي حاجة مهمة جدا لانها بتقول انها بتنسي لدرجة انها تنسي اسماء ولادها

**Aliaa Omar El-hady**

و علي فكرة بتؤكد ان اللي عندها ده صدفية وبتتعالج منها من زمان وكانت متابعة مع  
ا.د.الظواهري

**Aliaa Omar El-hady**

اما باقي الشكوي فقط من شهرين

**Amal El Ganzoury** dear Dr Aliaa thanks for the interesting case.

Dr. Omer I am suggesting it is 1ry phospholipid is not certain but anti DNA \_ve more over all the signs of inflammation are normal if it is neuro lupus in activity inflammatory markers should be high. more over further investigation can clarify C3 C4 anti smith repeating ANA and anti DNA will definitely help

**Howaida Elsayed Mansour** Dear dr.**Omer Mala Ahmed** , untill now no definite objective data to diagnose lupus why :

1- ANA, DNA both are negatives ESR 12 to diagnose lupus you should have at least 4 criteria ....at least one of them should be clinical and one is immunological. ..we didnt have this untill now....2- The amnesia and cognitive deterioration are well known in 1ryAPS due to recurrent showers/vasculitis ( without lupus ), till now we didnt have any objective prove of lupus cerebritis /vasculitis as MRI not yet done ....

3- This pateint start her illess by recurrent thrombotic episodes without any clinical data to suggest lupus (no oral ulcers, fever, polyserositis, arthritis...etc)

That is why till now she is 1ry APS but she has some data indicates that she may convert to lupus soon these are:

- 1- Neutropenia
- 2- Excessive hair loss
- 3- Psoriasis may associate lupus...

Thats why C3, C4, prot/creat ratio and MRI brain are very important. .

**Tamer Elfarahaty** Dear all; nice case and discussion . For me this case is 1ry APS with possibility of lupus transformation Need follow up to find out new manifestation &work up of SLE (ANA by INF ;antiRO as SLE negative ANA may be postive anti RO . ;C3 4 & prot /cret ratio). Pshyscatric & neurological manifestation (MS like lesion)may be a part of APL. MRI brain

is helpful for detect any micro thrombi . Vit D assay as decrease vit D may aggravate amnesia ;hair loss and numbness. psoriasis may be associated .Marivan 5 mg preceded by LMWH. Vit D 800 IU &Ca 1000 mg as anticoagulant & breast feeding can decrease Bone density with risk of osteoporosis .HCQ with antithrombotic effect but with caution as may worsen psoriatic lesion .

**Samar Hussien Huzien** • Blood in stools seen by patient ..

- Urine analysis .. Pus cells ++
- No history of Abortion ..
- She complains severe itching and inflammation in genitalia ..
- Photosensitivity

**Howaida Elsayed Mansour** Samar Hussein did you speak about the same patient of dr.Aliaa? ? If so think in lupus mesenteric vasculitis /with or without mesenteric vascular occlusion, that should be treated by pulse solomedrol 1gm daily for 3 days + cyclophosphamide For itchy genitalia, pls add deflocain 150 mg cap every 3 days for one week each month for 6 months , this is likely candidiasis it is common in immunocompromized patients...

**Mona Mansour** If fresh blood consult surgery, if occult ask for history of drug intake, if considerable you may be better to stop anticoagulants till you know the etiology of bleeding. Perform culture and sensitivity test for urine , consult derma for skin and mucous membrane lesions. Give zyrtic 10 MG or telfast 180 till you consult derma

**Aliaa Omar El-hady** Updating in our case: Serum protein electrophoresis shows polyclonal hypergammaglobulinemia - Urine analysis (turbid- pus cells 10-12- RBCs 4-6- no casts or epithelial cells or crystals)- RF <10 - AntiCCP negative- CRP = 2.08- ESR 1st 12, 2nd 26- protein creatinine ratio in urine 0.09 (N.up to 0.15)- Anti Sm, Anti La & Anti Ro negative - C3 & C4 normal- Alb/Creat normal- vit D= 5.1 (deficiency)

**Aliaa Omar El-hady** Drs. Howaida Elsayed Mansour- Mona Mansour- Omer Mala Ahmed- Basant Esawy- Amal El Ganzoury- Tamer Elfarahaty- Mohammed Hassan



**Basant Esawy** Thank u dr **Aliaa Omar El-hady** for updates  
So it is primary APS  
Anti cardiolipins should be repeated after 12 weeks ...**See More**  
**Aliaa Omar El-hady** thank you Dr. **Basant Esawy** for your  
valuable recommendations

**Tamer Elfarahaty** Primary APS. Severe vit D deficiency which  
may explain amnesia ; hair loss & numbness or at least  
aggravate it. Also; vit Deficiency may increase risk of  
thrombosis as dr **Basant Esawy** said . So need vit D3 50000 IU  
twice weekly for 3 months .

**Aliaa Omar El-hady** thank you Dr. **Tamer Elfarahaty** for your  
valuable recommendations

**Mohammed Hassan** thanks dr Aliaa , we now exclude SLE and  
it's clear it's 1ry APS and i agreed with dr Basant and dr tamer  
about vit D  
**Aliaa Omar El-hady**

**Howaida Elsayed Mansour** Dear dr. **Aliaa Omar El-hady** the  
diagnosis is the same 1ry APS just correct vit D deficiency by  
bone one 1mg daily + calcium, you may give a loading dose of  
vit D to fulfill the depleted stores by Devarol 200.000 IU  
weekly for a month then continue on oral therapy  
**Aliaa Omar El-hady** Many thanks Prof. **Howaida Elsayed**  
**Mansour** for your valuable recommendations.....

## Case58

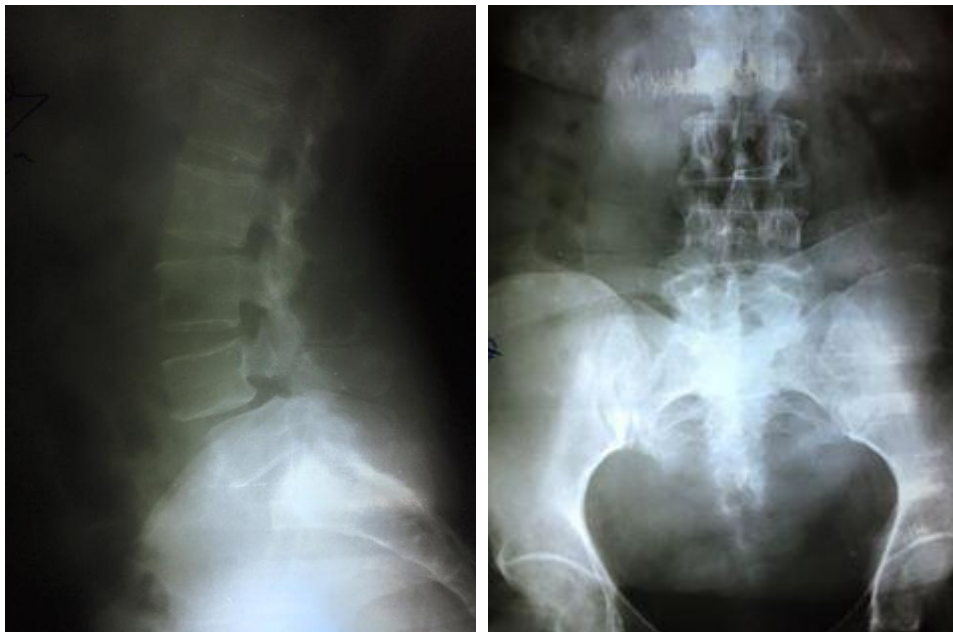
**Omer Mala Ahmed**

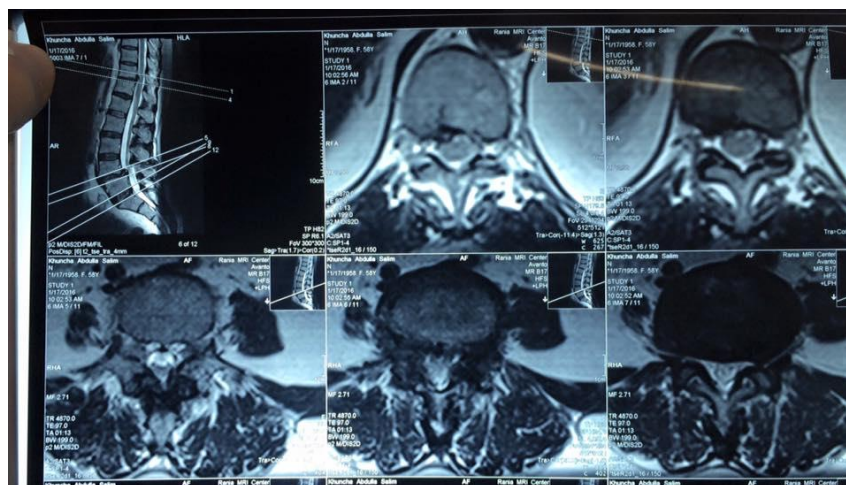
January 27 at 11:10pm · Ranya, Iraq

55 years old female patient with low back pain & bilateral sciatica, left lower limb neurogenic claudication .

□ How we manage this case ?

Can she get benefit from conservative treatment?





**Omer Mala Ahmed** Dear profs & Doctors:  
**Rageh M. Elsayed** , **Muhammad Dughbaj**, **Sherry Kamel**, ...  
**Mona Mansour** It is a case of degenerative disc lesion mainly at L4-5 with secondary first degree spondylolisthesis  
 DEXA scan should also be done at the hip to assess BMD away from the spine with some osteophytosis.  
 The management is NSAIDS for 7-10 days (choose bet cox 1 & 2 according type to associat) with Lyrica 75 1×2, muscle

relaxant and neurotonics , physiotherapy in form of heat ,  
ultrasounic waves, massage for the lumbosacral region,  
isometric exercise for the abdomina, knee hugging over chest  
exercise. The patient should wear lumbosacral support with  
paraspinal bars , lose weight if obese, follow back care  
instructions, follow up after 1 month. Please ask for serum creat,  
SGOT, SGPT and CBS.

**Omer Mala Ahmed** Great thanks dear prof **Mona Mansour** for  
your very informative comment

**Rageh M. Elsayed** Thanks dear **Omer Mala Ahmed** for  
common case presentation in every day practice I agree with  
prof **Mona Mansour** regarding treatment I have some points 1-  
usually spondylilythesis associated with flat feet and so  
increased lordosis try to correct pes planus and avoid increase  
weight and hyperextention of the back rigid lambosacral belt  
will be good choice and wt reduction

2- yes weakness of abdominal muscles esp internal oblique and  
weakness of multifidus are common beside tight iliopsoas  
muscle which is the missed link in almost all back problem esp  
spondylilythesis as it increases lordosis all must deal with

3- malalignment of the pelvis must be corrected with  
manipulation of the above or the below vertebrae esp in grade 1

4- usually start abdominal exercises and proceed to quadruped  
exercise of multifidus is very helpful then proceed to core  
stability program

5- technique of flexion distraction table is very helpful in grade  
1 or 2 creating backword pressure and may be associated with  
lateral bending I have this table in my facility in KSA and  
actually is very effective in low grade slipping

6- traction can be used with caution but flexion distraction is  
much better thank a lot good luck

**Omer Mala Ahmed** Great thanks Dear Dr **Rageh M.**

**Elsayed** for your very informative comment , i want to direct  
some questions to you :

- its necessary for these patients to wear the rigid coarset all the  
time ? Day & night ?
- can you post the useful exercises for these cases in general ?

- can you upload the videos for manipulation of the vertebrae to decrease the range of vertebral slippage at the area of listhesis ?
- Flexion distraction is the technique of cervical manipulation ?

Can you upload the video ?

GREAT GREAT REGARD MY DEAR

**Rageh M.**

**Elsayed** [https://m.youtube.com/watch?v=\\_aC8CSIDXsg...](https://m.youtube.com/watch?v=_aC8CSIDXsg...)

**Omer Mala Ahmed** Great thanks Dear Dr Rageh M. Elsayed



## Abdelrahman Amer

February 17 at 11:08pm

70 years old male complain of numbness & tingling of Rt hand

### ✓ Exam of UL:

- swelling on flexor surface of lower 1/3 Rt arm, movable partially cystic
- swan neck
- Z shaped thumb
- radioulnar subluxation
- no arthritis

### ✓ Exam of LL:

Cystic swelling of Rt ankle

Swelling of Lt ankle

Both swelling not tender & not hot

Normal ROM of both ankles

No arthritis

### ✓ Lab inv:

-CBC: HB 12..WBCs 12000...GRA 9.6...PLT 385000

-ESR 75

-CRP 12

-RF -ve

-S.uric acid 5

-S.creatinine 1.1

-S.albumin 2.5

-S.bilirubin 0.8

-HBs Ag -ve

-HCV Ab -ve

✓ US on lower 1/3 arm shows swelling partially solid , partially cystic 36\*19mm no vascularity

✓ xray hand: JA osteoprosis..narrowing PIP & DIP ... no erosions

✓ Xray knee : narrowing both medial & lateral compartments

✓ xray hip : narrowing joint space and osteophytes

✓ xray hips & knees shows periosteal bone formation ?

✓ waiting results of MRI on swelling on arm & ankle ...EMG & NCV median & ulnar nerve

What do you think about management of this case?

























**Mohamed Maher** History of complaints since what?

What about morning stiffness?

Anti ccp

Examination of sacroiliac joint?

**Abdelrahman Amer** Since 1 month...no MS ...antiCCP not done

**Abdelrahman Amer** SIJ normal

**Omer Mala Ahmed** Thanks for sharing this case dear Dr Abdelrahman Amer.

- I think the Rt hand changes are of more than 1 month duration & they are from long standing underlying neurological deficit like cervical radicular problems...
- these swellings in multiple areas need perfect MAKUS to see if they are from the joints or if they are from periarticular structures like tendons ( tenosynovitis ) .
- if possible please aspirate the fluid from these swellings & send it for microscopic analysis ( WBC , crystals & LDH ) .
- the calcifications are along the vascular walls & they may be normal calcification of vascular walls as a consequence of the aging ?
- at this age we should think more about an underlying paraneoplastic causes behind the high ESR & arthritis of ankle , so also in need of CXR & abdominal US .

Great regards



**Abdelrahman Amer** Thank you for discussion..We asked for EMG ..NCV median and ulnar ...MRI on swelling in arm and ankle ..CXR normal...aspiration and analysis is a good idea smile emoticon

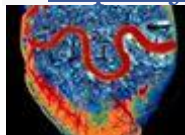
**Omer Mala Ahmed** Please update us on the Result of your next investigations & diagnosis

**Abdelrahman Amer** What is ur comment on xrays??

**Aliaa Omar El-hady** very nice case .... I agree with Dr. **Omer Mala Ahmed**..... need to do MSUS by expert ... aspirate & analyse ... search for malignancies ...thank you Dr. **Abdelrahman Amer** for sharing this nice case

**Abdelrahman Amer** Thank you ..No MSUS available now in Mansoura frown emoticon ..what is ur comment on x rays ?

**Aliaa Omar El-hady** any history of diabetes?? what is his complete renal function?? Any cardiac examination?? history of drugs as calcium containing phosphate binder?? we have to search for this extensive calcification of vessels ....<http://bjcardio.co.uk/.../vascular-calcification.../>



Vascular calcification: mechanisms and management

BJCARDIO.CO.UK|BY BRJCARDIOL

**Yara Tawfik** , waiting for updates . Question please , is the swellings pitting ??

**Abdelrahman Amer** Not pitting but soft and abnormal sensation ...like vesicles in a bag of water !

**Yara Tawfik** Why you dont ask for surgical consult ?

**Omer Mala Ahmed** Dear Dr **Abdelrahman Amer** regarding the X-Rays i just found evidence of severe osteoporosis , normal joints , calcification of arterial walls which may be part of aging process as According to the Mayo Clinic, calcification in the

arteries is most common in people ages 65 and older also it may be due to disorders of calcium metabolism, such as osteoporosis or hypercalcemia (eg due to hyper parathyroid)



Aliaa Omar El-hady



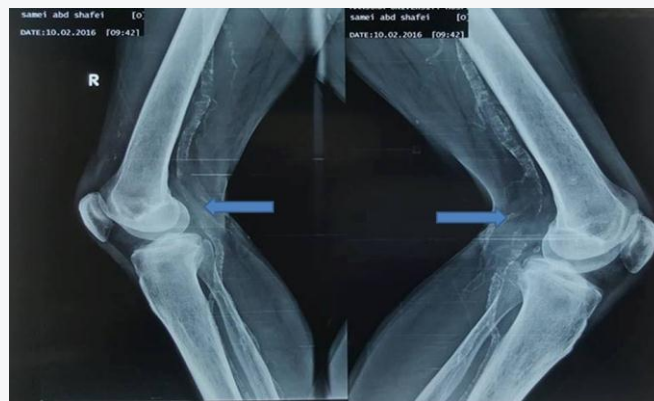
Aliaa Omar El-hady



**Abdelrahman Amer** What is orange circle plz? New periosteal bone formation? DD?

**Aliaa Omar El-hady** Yes..periosteal reaction

**Aliaa Omar El-hady**



**Aliaa Omar El-hady**



**Abdelrahman Amer** What is orange circle?

**Yara Tawfik** I think periosteitis .. dr **Aliaa Omar El-hady** whats your opinion ?

**Aliaa Omar El-hady** Enthesitis

**Yara Tawfik** Whats the difference radiologically my dear prof. ??

**Aliaa Omar El-hady**

يختلف عن lig. or tendon to bone المكان اللي خارج منه... مكان التقاء ال  
irritation of periosteum and periosteitis

**Aliaa Omar El-hady**

calcaneal spur is periosteitis but in tendoachilis it is  
ensethopathy

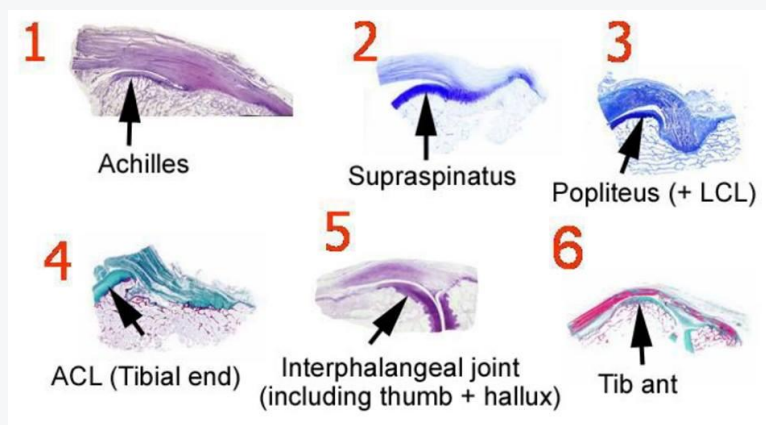
**Yara Tawfik**

anatomical site؟؟ هم شكلا واحد ، لكن الفرق ال

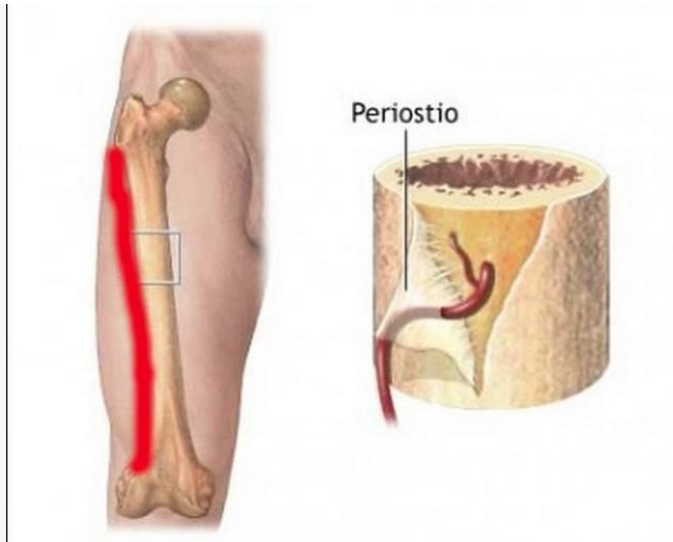
If a tendon attachment<-- enthesitis

If along a bone away from tendon, ligaments onsertion <--  
periosteitis

**Aliaa Omar El-hady** Diseases of the Enthesis are often associated with an abnormal reaction in the bone at a location that is well away from the actual insertion site.



**Aliaa Omar El-hady** Periostitis, also known as periostalgia, is a medical condition caused by inflammation of the periosteum, a layer of connective tissue that surrounds bone. The condition is generally chronic, and is marked by tenderness and swelling of the bone and an aching pain.



**Aliaa Omar El-hady** Periostitis



**Samarino Helal**

فتح الله عليكي د علياء فتاح مينا

**Abdelmoaty Afifi** This is a case of pseudo-RA, a variety of pseudogout.

**Abdelrahman Amer** Thank you prof **Abdelmoaty Afifi**



**Abdelmoaty Afifi** you welcome Dr. Abdelrahaman

**Yara Tawfik** Welcome d. **Abdelmoaty Afifi** . Whats your opinion in the swelling of the lower forearm ??

In psuedogout , polyarticular form , resembling RA , what can be seen in the joint ?? Many thanks in advance

**Abdelmoaty Afifi** This is a case of pseudo-RA, a variety of pseudogout.

**Abdelrahman Amer** Thank you prof **Abdelmoaty Afifi**

**Abdelmoaty Afifi** you welcome Dr. Abdelrahaman

**Yara Tawfik** Welcome d. **Abdelmoaty Afifi** . Whats your opinion in the swelling of the lower forearm ??

In psuedogout , polyarticular form , resembling RA , what can be seen in the joint ?? Many thanks in advance

**Abdelmoaty Afifi** Flexor Sheath Ganglion - base of a finger arising from the sheath around the tendons.

**Abdelmoaty Afifi** Symmetrical polyarticular pattern, especially involving wrists, MCP and PIP joints

**Abdelmoaty Afifi** Symptoms: morning stiffness, joint swelling

O/E: synovial thickening, localized edema, restricted joint motion, flexion contracture

Lab: positive RF in 10% in low titer

ESR may be elevated. X-ray:erosions may be observed

**Abdelmoaty Afifi** Differences from RA:

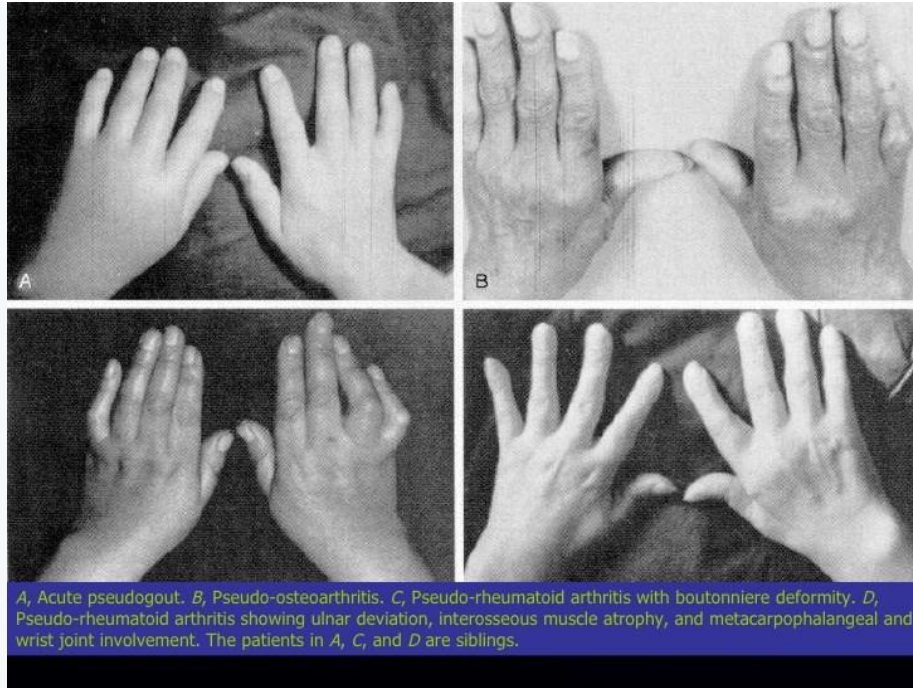
Older age at onset,

Less widespread synovitis,

Lack of high titer of RF,

Less erosion associated w/ chondrocalcinosis on radiographs

**Abdelmoaty Afifi**



**Aliaa Omar El-hady**

Prof. **Abdelmoaty Afifi** رائع جدا وتحليل ممتاز... جزاك الله خيرا استاذنا الفاضل

**Abdelmoaty Afifi**

وجزاكى خيرا مثله د. علياء

...

**Abdelmoaty Afifi** Basic Calcium Phosphate (BCP) crystals frequently co-exist with CPPD crystals and caused vascular calcification

**Abdelrahman Amer** US done by dr **Ahmad Negm** showing tenosynovitis in flexor sheath ..compression on median nerve ..CTS

## Case 60

Omer Mala Ahmed

February 21

□ CASE :

40 years old diabetic male patient presented to me complaining of Severe & very painful Rt Elbow & Rt Wrist arthritis

- The condition is migratory, few days ago involved the left knee , then left wrist then left shoulder & lastly involved the Rt elbow & Wrist .

- He has no fever or rigor

No skin rashes & mouth ulceration & Raynauds.

- He had history of the same attacks of migratory arthritis 3 times previously with 2-3 years intervals involving just large joints & sparing the small joints of hands & feet & he was free of symptoms between the attacks .

- He is not on Regular anti rheumatic drugs .

- The involved joints are very tender , hot with no skin color changes

- Temperature: 37.6 °C

□ INVESTIGATIONS:

- CBC : Unremarkable

- ESR : 50

- GUE : Normal

- CRP: Strongly positive ( 1/640 )

- ASO : Strongly positive (1/640 )

- Renal function:Normal

- Liver function:Normal

- RF: -ve

Anti-CCP : -ve

- ANA : positive ( 77.5 ) {N : 1.0 - 25 }

- CXR : Normal

- ECG : Normal

- Echocardiogram: Pending.

□ FOR YOUR KIND OPINIONS REGARDING DIAGNOSIS & TREATMENT?

Great Regards.



**Omer Mala Ahmed** Dear profs & Doctors  
**Howaida Elsayed Mansour**, **Abdelmoaty Afifi** , **Amal El Ganzoury** , **Mona Mansour** , **Tamer Elfarahaty**, **Mohamed Nabil Salem**, **Mohammed Hassan**, **Rageh M. Elsayed**, **Sherry Kamel**, **Basant Esawy**, .....

**Aliaa Omar El-hady** Any x\_ray of affected joint.. Any history of bowel disturbance.. His age is against rheumatic fever

**Samah Yosef** Resolved joints completely free after attacks  
palindromic rheumatism

**Basant Esawy** His age against RF

This is palindromic rheumatism

50% will continue to RA

Also Disseminated gonococcal arthritis usually migratory +\ -  
pustules , repeat urine analysis and culture

Sle but no a& s suggestive of Sle but migratory arthritis can  
occurs for DNA, ENA , c3 , c4 alb/ creat ratio

What about S Utica acid ?

MSUS on the affected joints

X-ray hands and elbows

MRI of the affected wrist if possible aspirate fluid and analyze  
**Howaida Elsayed Mansour** Dear dr. **Omer Mala Ahmed** to me  
Reactive arthritis (likely post stryptococal ReA ) is the 1st DD  
of this patient with recurrent migratory oligoarthritis of the large  
joints, 2nd DD is gonococcal arthritis - a form of reactive  
arthritis to gonococcal infection , 3rd DD is gouty arthritis but  
this is not rheumatic fever ....so please check for serum uric acid  
, and put him on salazopyrine 500 mg 1x3 + NSADS +  
hostacortine 5 - 10 mg tab daily + colchicine 1mg daily ( if gout  
is suspected ) good you give him penicillin to eradicate any  
remaining stryptococal infection

**Mohammed Hassan** thanks dear dr **Omer Mala Ahmed**  
i think we need CBC, Serum uric acid, plain x-ray of affected  
joints

the most common DD of migratory arthritis in this age are:  
ppoststreptococcal reactive arthritis, gonococcal arthritis,  
palindromic rheumatism, HCV arthritis, SLE,gouty arthritis  
i think in this case the most likely DD are poststreptococcal  
reactive artritis so continue investigations and start penicillines  
+ low dose GC+ 150 mg/d sulphasalazine

**Omer Mala Ahmed** Dear Dr **Aliaa Omar El-hady** really i not  
arranged for X-Rays of affected joints because not any join  
affected chronically & the Wrists are affected only in this attack  
, no history of bowl problem

**Omer Mala Ahmed** Dear Dr **Basant Esawy** thanks for your  
informative comment , yes the gonococcal arthritis may be one  
of the DD but he not gave history of skin pustules & GUE  
Normal.

Really i not thought about S.Uric acid checking because he had  
no history of Attacks of single joint arthritis especially podagra  
& as you know the migratory pattern is usually occurs in late  
stages of gouty arthritis after recurrent attacks of monoarticular  
gouty arthritis , i not arranged X-ray of hands because the wrists  
are involved only in this attack during the whole course of the  
disease .



**Omer Mala Ahmed** Dear prof **Howaida Elsayed**

**Mansour** thanks alot for your golden comment , could PSRA be migratory or its usually persistent oligoarticular ? Could gonococcal arthritis happen without skin pustules or normal GUE & no history urethral discharge ?

As you know The migratory gouty arthritis is usually occur before the gouty arthritis transform to polyarticular form & after recurrent attacks of mono arthritis of lower limb joints usually in the form of podagra , he not gave such history that made me not think about gouty arthritis□

I putted in my mind to use a short course of steroid but because of high blood sugar ( today at 7pm the R.B.Sugar was 270mg/dl ) I decided to not give him the steroids.

Also I wanted to put the patient purely on ASA to help me in reaching the diagnosis ( see response within 24-72 hrs) this help me in diagnosis of ARF

**Rageh Elsayed** Thank dr **Omer Mala Ahmed** no criteria even the age with ARF for me DD 1- ReA 2- palindromic rheumatism 3- gouty orCPPD we need aspiration with analysis and MSUS to narrow DD I agree with your mangment but I think you must add cholchicine bid CS 10mg and full dose NSAIDs

**Sherry Kamel** dear dr.**Omer Mala Ahmed**, I think ti is post reactive streptococcal arthritis, which can be presented like other reactive arthritis by migratory arthritis ,also 2nd DD is gouty arthritis , gouty arthritis is commonly precede by attack of mono arthritis , but can be presented by oligoaricular form .

**Omer Mala Ahmed** Dear Dr **Mohammed Hassan** thanks for your informative comment, he did CBC 3 times previously & they were normal, unfortunately I missed s.Uric acid testing & he will return tomorrow or latter & will check it.

**Howaida Elsayed Mansour** Yes dr **Omer Mala Ahmed** PSRA can be migratory. ...and migratory gonococcal arthritis can occure without a definite history of skin papules... (may be overlooked bec it is non ietchy and painless papules ...and blood culture may be positive ) and gout should be ruled out even if the history is not typical in a 40 years old male...

**Omer Mala Ahmed** Thanks Dear Dr **Rageh M. Elsayed** for your nice interpretation, but what made me not think about PARA is the presence of migratory patterns, unfortunately we have no perfect MSKU to check for uric acid crystals & believe me we have no polarized microscope to check for crystals □, so most of our diagnosis are clinical □

**Rageh Elsayed** Yes d **Omer Mala Ahmed** as prof **Howaida Elsayed Mansour** said it can be migratory good luck May God help all of us

**Omer Mala Ahmed** Dear prof **Howaida Elsayed Mansour** thanks allot for this interesting point because This is the first time i hear that PSRA could be migratory & in most books written that by migratory pattern we can differentiate arthritis ARF from the arthritis of PSRA □

Yes I will check for S.Uric acid level .

He got the first attack of this type of arthritis about 15 years ago when he was 25 years old & he said at that time most of my great joints were affected in upper & lower limbs & I couldn't walk at that time & made me bedridden!

I gave him appointment for tomorrow or days latter, i said to my self if he not showed dramatic response to ASA I will start Steroid, but this should be incorporation with Internist to avoid further elevation of Blood sugar.

Can exclude ARF from the list of DD in this case from now?

**Howaida Elsayed Mansour** Yes this is not RF

**Omer Mala Ahmed** Thanks dear dr **Sherry Kamel** thanks for your informative comment , i check for S.Uric acid inshallah

**Tarek Afifi** Thanks d omar about your interesting and learning cases i think If dramatic response to long acting penncillen It ls A R fever if not it is PsRA many thanks to you again

**Omer Mala Ahmed** Great thanks dear Dr **Tarek Afifi** for your informative comment

**Tamer Elfarahaty** 1)Age ;no fever & no redness of involved joints against ARF( wait ECHO) . 2) for me this a case of

episodic migratory arthritis mostly reactive arthritis ; put him on full dose NSAIDs & SAZ and follow up. 2) also need to rule out other possible causes of episodic arthritis : crystals induced arthritis ; I think if MSKU & polarized microscopy are not available ; Dual energy CT is helpful for detecting urate crystals . 3) palindromic arthritis which may be RA later on with positive ANA ( although RF - ve & not involve small joints. Aniccp was done or not? ) . 4) Also rule out HBV arthritis .

**Omer Mala Ahmed** Thanks alot prof **Tamer Elfarahaty** for your informative comment, the arthritis of ARF should be associated with redness ? Temp 37.6 °C .

Uric acid induced arthritis also should not be associated with redness?

Liver enzymes were normal that made me not think about HBV or HCV , am i right ?

**Tamer Elfarahaty** 1) I means Redness is characteristic for ARF ;but its absence is not against ARF diagnosis . 2) acute gouty arthritis : commonly with redness especially in podagra. 3) yes ; hepatitis B induced arthritis is the last one of possibilities in your case . although majority of patients with Hepatitis associated arthritis have liver enzyme elevation at onset of arthritis ;but normal liver enzymes (or mild elevation) don't exclude hepatitis infection & hepatitis markers are diagnostic if you suspect it

**Omer Mala Ahmed** Great thanks dear prof **Tamer Elfarahaty** for your very informative comments ☐☐☐

**Omer Mala Ahmed** Dear profs & doctors :  
**Howaida Elsayed Mansour**, **Basant Esawy**, **Sherry Kamel**, **Aliaa Omar El-hady**,**Mohammed Hassan**,**Rageh M. Elsayed**, **Tarek Afifi**, **Tamer Elfarahaty** , **SamahSamah Yosef** ....

Update regarding my case :

After i gave him one vial of Benzathinepenicilline 1.2 00000 iu & daily 6 gm ASA in 4 divided doses & i gave him appointment to return to me after 3 days , but he not returned to me for that time , i lost his phone number so i asked one of his relatives to

call him & tell him why he not returned ?! He said that he got a great benefit from ASA & all his joints were improved ! But after he finished the ASA the condition was returned with severe Rt mid foot arthritis & associated redness , so he returned to with that pain , i sent for S.Uric acid & it was 3.6 mg/dl ( normal ) .

So with the advices of all of you i diagnosed the case as PSRA & i started SSZ 2gm/day + prednisolone 10mg/day & Ca+Vit D

.

**Omer Mala Ahmed**



**Howaida Elsayed Mansour** He is likely a case of intermittent attacks of gouty arthritis his foot swelling, redness and 1st MTPj swelling look like acute gouty arthritis. ...s.uric acid may be normal or even low during the acute gouty arthritis attack. ... that's why he improved on ASA before...please add colchicine + NSAIDS + 5 mg steroids, plenty of fluid and diet restrictions of gout



**Mona Mansour** I agree with Dr **Howaida Elsayed Mansour** that it is most likely gouty arthritis . I think adding one ampule of ACTH could help and it will not elevate his blood sugar much + cold packs elevation, use of a cane to decrease weight bearing . Dose of colchicine 2 tab separated by one hour in the first day then once daily .

**Basant Esawy**

## 2015 ACR-EULAR Gout Classification Criteria

(1)

| Criteria (to be used if Sufficient Criterion not met):<br>Score ≥8 required for classification as gout |                                                                                                                                                                                                                                                                    | Categories                                                                                                                                | Score |
|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------|
| CLINICAL                                                                                               | Pattern of joint/bursa involvement during symptomatic* episode(s) ever                                                                                                                                                                                             | Joint(s) or bursa(e) other than ankle, midfoot or 1 <sup>st</sup> MTP (or their involvement only as part of a polyarticular presentation) | 0     |
|                                                                                                        |                                                                                                                                                                                                                                                                    | Ankle OR midfoot (as part of monoarticular or oligoarticular episode without MTP1 involvement)                                            | 1     |
|                                                                                                        |                                                                                                                                                                                                                                                                    | MTP1 (as part of monoarticular or oligoarticular episode)                                                                                 | 2     |
|                                                                                                        | Characteristics of symptomatic episode(s) ever:<br>i) erythema overlying affected joint (patient reported or physician-observed)<br>ii) can't bear touch or pressure to affected joint<br>iii) great difficulty with walking or inability to use affected joint    | No characteristics                                                                                                                        | 0     |
|                                                                                                        |                                                                                                                                                                                                                                                                    | One characteristic                                                                                                                        | 1     |
|                                                                                                        |                                                                                                                                                                                                                                                                    | Two characteristics                                                                                                                       | 2     |
|                                                                                                        |                                                                                                                                                                                                                                                                    | Three characteristics                                                                                                                     | 3     |
|                                                                                                        | Time-course of episode(s) ever:<br>Presence (ever) of ≥2, irrespective of anti-inflammatory treatment:<br>i) Time to maximal pain <24 hours<br>ii) Resolution of symptoms in ≤14 days<br>iii) Complete resolution (to baseline level) between symptomatic episodes | No typical episodes                                                                                                                       | 0     |
|                                                                                                        |                                                                                                                                                                                                                                                                    | One typical episode                                                                                                                       | 1     |
|                                                                                                        |                                                                                                                                                                                                                                                                    | Recurrent typical episodes                                                                                                                | 2     |
|                                                                                                        | Clinical evidence of tophus: Draining or chalk-like subcutaneous nodule under transparent skin, often with overlying vascularity, located in typical locations: joints, ears, olecranon bursae, finger pads, tendons (e.g., Achilles).                             | Absent                                                                                                                                    | 0     |
|                                                                                                        |                                                                                                                                                                                                                                                                    | Present                                                                                                                                   | 4     |

## 2015 ACR-EULAR Gout Classification Criteria

(2)

|                      |                                                                                                                                                                                                                                                                                                                                                |                                           |    |
|----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|----|
| LAB                  | Serum urate: Measured by uricase method. Ideally should be scored at a time when the patient was not taking urate-lowering treatment and patient was beyond 4 weeks of the start of an episode (i.e., during intercritical periods); if practicable, repeat under those conditions. The highest value irrespective of timing should be scored. | <4mg/dL [ $<0.24\text{mM}$ ] <sup>†</sup> | -4 |
|                      |                                                                                                                                                                                                                                                                                                                                                | 4-6mg/dL [ $0.24-0.36\text{mM}$ ]         | 0  |
|                      |                                                                                                                                                                                                                                                                                                                                                | 6-8mg/dL [ $0.36-0.48\text{mM}$ ]         | 2  |
|                      |                                                                                                                                                                                                                                                                                                                                                | 8-10mg/dL [ $0.48-0.60\text{mM}$ ]        | 3  |
|                      |                                                                                                                                                                                                                                                                                                                                                | ≥10mg/dL [ $≥0.60\text{mM}$ ]             | 4  |
| IMAGING <sup>‡</sup> | Synovial fluid analysis of a symptomatic (ever) joint or bursa: <sup>**</sup><br>Should be assessed by a trained observer.                                                                                                                                                                                                                     | Not done                                  | 0  |
|                      |                                                                                                                                                                                                                                                                                                                                                | MSU negative                              | -2 |
|                      | Imaging evidence of urate deposition in symptomatic (ever) joint or bursa: Ultrasound evidence of double contour sign <sup>§</sup> or DPC1 demonstrating urate deposition <sup>¶</sup> .                                                                                                                                                       | Absent OR Not done                        | 0  |
|                      |                                                                                                                                                                                                                                                                                                                                                | Present (either modality)                 | 4  |
|                      | Imaging evidence of gout-related joint damage: Conventional radiography of the hands and/or feet demonstrate at least one erosions. <sup>**</sup>                                                                                                                                                                                              | Absent OR Not done                        | 0  |
|                      |                                                                                                                                                                                                                                                                                                                                                | Present                                   | 4  |
| TOTAL SCORE          |                                                                                                                                                                                                                                                                                                                                                |                                           |    |

Maximum score is 23. Threshold to classify as gout is ≥8.

**Sherry Kamel** Thanks DR.Basant.

**Basant Esawy** As my colleagues mentioned normouricemic gout could be DDX , but SUA < 4 equal -4  
So if we considered maximum clinical score without tophus so we will get 7  
So with lab 7-4 =4  
So u still need proof of synovial fluid for mono sodium urate crystals or double contour sign in MSUS  
Also still reactive arthritis or PSRA is DDX ( oligoarticular, mainly LL with good response to NSAIDs, on and off acute attacks) Midtarsal and MTP could be included  
So for MSUS. And full dose NSAIDs and ACTH inj once / w for 2 ws

**Omer Mala Ahmed** Thanks allot dear Dr Basant **Basant Esawy** Really i not understood the number 4 ?!□  
Unfortunately we have no Polarized light microscope or perfect MSKU to detect the uric acid crystals □  
I did the above S.uric acid when the inflammation settled Down & at that time the had no arthritis , i took this foot picture from the patient's smart phone.

**Basant Esawy** If u have SUA < 4  
So 4 should be subtracted from The calculated score so at that time u will not get 8 unless u have tophus  
So clinical alone without tophus will not help that's why either polarized microscopy or double contour sign  
It is easy to be detected by MSUS you can tell ur radiologist and observe with him on the first MTP  
Tell the radiologist to take care that cartilage interface could mimic double contour but it is fixed in all directions in double contour

That's why the DDx of reactive arthritis and PSRA is still there

Regarding ur examination

Is the arthritis in first MTP or Midtarsal ?

Is there any erythema or not as ur photo is not clear ?

[Basant Esawy](#) [Omer Mala Ahmed](#) so if first MTP not affected unlikely to be gout as he will not get the score

Regarding ur pt SUA is  $< 4$  mg

Which is 3.6 so if u apply the score

1-Typical acute attack will get 2

2- chch of affected joint (as no erythema) so u will get another 2

3-joint affected score 2 and if first MTP it will be 3

So ur pt now has got score 6

SUA  $> 10$  mg = 4 points

SUA 8-10mg = 3points

SUA 6-8mg = 2points

SUA 4-6mg = 0points

SUA $<4$ mg = minus 4 points in that state as ur pt 6-4=2points

Which is away from 8 points score so you should have radiological MSUS +\\_erosion in X-ray and polarized microscope

I hope u get it now

[Basant Esawy](#) There is no link just apply Acr calcification criteria I posted earlier

[Omer Mala Ahmed](#) Great thanks my dear dr [Basant Esawy](#)for your informative comment ☐☐

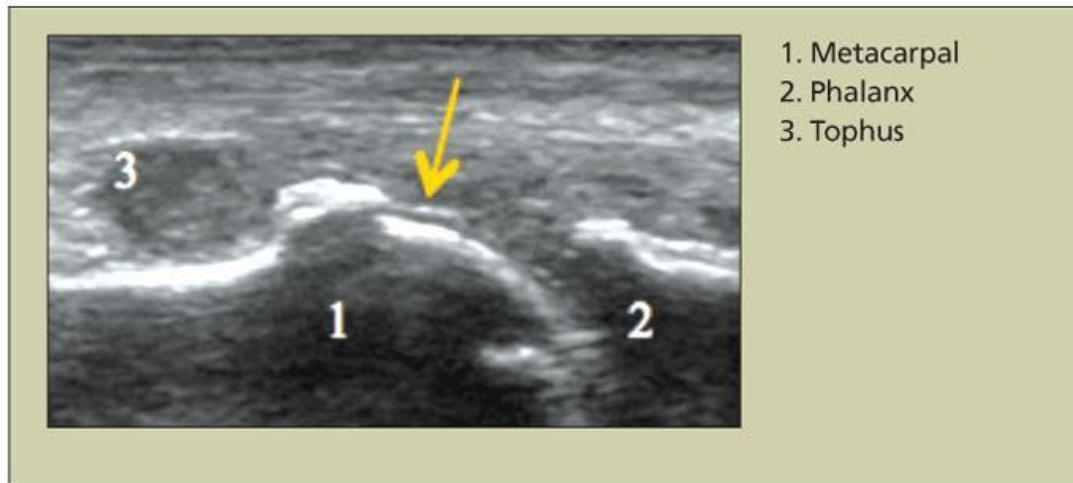
[Omer Mala Ahmed](#) Dear prof [Howaida Elsayed](#)

[Mansour](#) thanks again , i took this picture from the patients smart phone , really i not saw foot by my eyes but he said that the arthritis was affected the ankle & he said that the condition never affected the MTP joints !

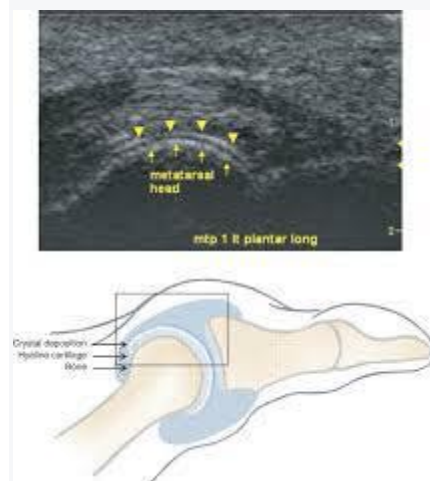
I took the blood sample for uric acid counting when the patients ankle arthritis settled down two days before . Still you say its Gouty arthritis or PSRA ?

The patient said for the first time i suffered from attacks of arthritis when he was 15 years old after an attack flue like condition .

[Basant Esawy](#)



## Basant Esawy



**Howaida Elsayed Mansour** Dear all, the 2015 classification criteria is just a "classification " not diagnostic criteria ...each criteria has its limitations and sensitivity....I was the 1st one to say it is PSRA .... ( before seeing the patient photo) but I think the patient did a great job for us when he photographed his foot during the attack this was very helpful... if you add this to the patient age and sex...(40 years old male ) then the smell of gout is very strong....!! another point is the redness very obvious over the skin of the 1st MTPJ. .. ( if he has med tarsal joint pains + ankle pain and the whole foot swollen then believe me it is very difficult to rule out inflamed 1st MTPJ. ...I think dear dr [Omer Mala Ahmed](#) even the beginners in MSU can detect double



contour. ..just try..! to me I'll give him full dose NSADs + 5 mg hostacortine + colchicine 1mg daily + plenty of fluid

**Omer Mala Ahmed** Yes you are right dear proph **Howaida Elsayed Mansour** , i will try to arrange for MSKUS but iam sure non of our US practitioners can detect even the synovitis , yes you are right the age & the joint redness goes mostly with Gout , but what made me doubtful is the patient's past history of the first attack when he was 15 years old & he said i got this condition at that time after a flue like disease !!

## Case 61

**Heba Nagieb**

February 24

السلام عليكم  
بعد اذنكم جاتلى حاله 2.6- forearm osteoporosis و hip and spine  
normal  
و عاملة 15 year since hystrectomy  
تاخذ aclasta و لا لا

**Ali Mursi** You may measure but D and calcium 1st if normal  
give aclasta if creatinine clearance above 35

**Samarino Helal** f

## Case 62

### Omer Mala Ahmed

February 23 - Ranya, Iraq

#### ☐ Case :

60 years old postmenopausal woman presented with acute Rt mid foot arthritis .

Had history of the same condition affecting alternating mid feet.

☐ PMH : Hypertension + DM + Heart failure with attacks of pulmonary edema .

☐ Drug history: Too much ! Including:

- ARB (Candisartan )16 mg/day

- Two Diuretics:( Spironolactone 25mg + Bumetanide 1mg )

- Aspirin 100mg /day

\* INVESTIGATIONS:

- CBC : Normal

- ESR: 60

- CRP:

+++ Strongly positive

- B.Urea :

61 mg/dl ( N: up to 45)

- S.Createnin:

1.6 mg/dl ( up to 1.2 )

- S.Uric acid: 9.2 mg/dl

☐ DIAGNOSIS:

Gouty Arthritis

☐ How we manage this case ?

Note : her we have no Febuxostat ☐



**Omer Mala Ahmed** Dear profs & Doctors  
Howaida Elsayed Mansour , Tamer Elfarahaty, Mona Mansour, Fatemah Elshabacy, Basant Esawy,Mohammed Hassan, Amal El Ganzoury, Sherry Kamel....  
**Amal El Ganzoury** Thanks dr Omer for the interesting case

I would like to do creatinine clearance if we have severe degree of renal affection febuxostat will be drug of choice mild moderate degree we can give harpagin which is zyloric 100 + urocosuric agent mostly it will be effective in addition to:

drugs that contain thiazide should be stopped it causes hyperuricemia.

diet restriction for purine

colchicine can be given in the acute phase, moreover it can be given in small doses for prevention

small dose of steroids can be given in acute phase and rapidly tapered in such case with quite comorbidities

[Abdelrahman Amer](#) thank you prof [Amal El Ganzoury](#) smile emoticon

[Abdelrahman Amer](#) Dear dr [Omer Mala Ahmed](#) thanks for sharing this case ..as management of acute attack you can give ACTH as a safe option (Synacthen Depot Ampoules 1mg/ml IM one amp & another 2nd day ) & colchicine( do creatinine clearance and if more than 30 ml/min it is safe ) ...avoid steroid as DM & HTN ...Avoid NSAID as renal impairment

[Mohammed Hassan](#) nice as usual dear fr omer ..... in acute state we aimed to decrease inflammation by colchicine 1mg/d +ACTH + cold pack and rest ..... stop thiazides and increase fluid intake ... plz in acute state not to give urate lowering agent until acute state ends to avoid exacerbation . after ending of acute state add zyloric 300 mg/d

[Basant Esawy](#) Nice case as usual dr [Omer Mala Ahmed](#) Management of acute gouty attack with renal impairment First as my colleagues mentioned calculate cr clearance Then start to treat the acute inflammatory status by colchicine if cr cl>30

Synacthen depot ( ACTH like action) is a good option for DM but follow blood or weight due to its salt and water retention



effect

After the pt being completely free from the acute attack at least 1-2 weeks start allopurinol 100 mg po od with dose escalation according to cr clearance and s Uric acid level  
Diet control , change thiazide if possible as you mentioned  
plum edema

**Basant**

**Esawy** [http://www.rheumatology.org/.../Files/Gout\\_Part\\_2\\_ACR-12.pdf](http://www.rheumatology.org/.../Files/Gout_Part_2_ACR-12.pdf)

<https://www.rheumatology.org/.../ACR%20Guidelines%20for...>

**Howaida Elsayed Mansour** Dear all dear dr. **Omer Mala Ahmed** she is likely a case of acute gouty arthritis we need to stop not only thiazide but also low dose aspirin as it is a common cause of acute gouty attack. ..put her on febuxostat + colchicine 1mg daily + hydrocortisone 5 mg daily  
DD is Rs3PE

**Omer Mala Ahmed** Thanks prof **Howaida Elsayed Mansour** , we can replace Aspirin by Clopidogril but unfortunately we have no Febuxostat ☐

**Mona Mansour** Dear Dr. Omer Mala : I agree with my colleagues dr. Amal, Dr. Howaida, and Basant , I would like to add to the investigation serum lipid profile as it seems that the patient may have the full aspect of the metabolic syndrome. Adding statins will be beneficial for her regarding lipid and s. uric acid level control.

**Ali Mursi** According to the book pearls and myths in rheumatology you can continue aspirin 75 and stop thiazide diuretic and increase dose of spironolactone if the patient was on ULT don't stop them if not give it after one week of treatment of acute attack as mentioned above by allopurinol according to creatinine clearance

**Omer Mala Ahmed** So dr Ali **Ali Mursi** what drugs in this case you advice to be stopped?

**Ali Mursi** Thiazide diuretics [See Translation](#)

**Omer Mala Ahmed** Dear Dr Ali **Ali Mursi** She only taking Frusemide & Bumetanide which they are Loop diuretics, also taking Spironolactone which is potassium sparing diuretic, so she already not taking Thiazides!

**Ali Mursi** The recommended diuretic is spironolactone

**Ali Mursi** As it isn't cause hyperuricemia

**Omer Mala Ahmed** So you advice to stop Bumetanide & Frusemide? Thanks allot ☐

### Case 63

**Dalia Hussien Kamel**

February 28

55yrs male pt complaining from numbness & MS of one yr duration

Exam. revealed tenderness on all MCP, PIP & MTP but no active synovitis

ESR 25

RF >32

ALT 9

AST 11

WBC 6.9

BL urea 37

S.creat 1.06

Is this case RA?







**Ahmed Abdulbari** 1-when you have like this case  
We can do musculoskeletal ultrasound to see the synovial hypertrophy or synovitis  
2-You didn't have CRP CRP  
Because sometimes we have active RA with normal ESR  
**Dalia Hussien Kamel** Is there any radiological finding? I think periarticular osteopenia



محمد عبد الفتاح I see nothing about rheumatoid arthritis. Is the case diabetic or not u talk about arthralgia or arthritis. I didn't observe any thing about inflammation. Is the pain specific to joints or the whole hands.

محمد عبد الفتاح Is there any complaint about stiffness.

محمد عبد الفتاح I just see mild osteoarthritic changes in carpal bones and lead toxicity signs.

**Youssy Said** MS??? MORNING STIFFNESS? ? FOR HOW LONG???

**Dalia Hussien Kamel**

محمد عبد الفتاح the pt isn't diabetic he complain from numbness & mention that his hands have oedema(or effusion) in the morning & stiffness that last for about 45. min but I dout. I asked him for CRP & NCS. I want to know, plz, when we have local tenderness on the joint this mean it has synovitis & ?we count it as affected joint or it should have effusion, redness, hotness or limited ROM?

**Dalia Hussien Kamel**

د محمد عبد الفتاح

محمد عبد الفتاح By looking to this pt hands, I saw no inter meta carpal heads fullness so, it's nothing or the pt is in the inactive state. Arthritis means what u said before. If you are doubt about something, u can request ultra sound.

محمد عبد الفتاح Above all, if you suspect rheumatoid arthritis, u can request accp

**Dalia Hussien Kamel** But accp will give us the same score of RF w' is already positive

**Dalia Hussien Kamel** So, tenderness alone doesn't mean synovitis? it mean what?

محمد عبد الفتاح Tenderness means something wrong from skin to bone. Not a must to be a synovitis. So, tenderness is graded and u can't by it alone judge a case.

محمد عبد الفتاح Synovitis especially if chronic. Pannus must be associated with swelling which is not here.

محمد عبد الفتاح What treatment to this case she had

**Dalia Hussien Kamel** Just NSAIDS ,he is amale

## Case 64

### **Amaly ElJana**

February 29

A 6 years female patient suffers from neck pain for 3 months. there was spasm in neck muscles. she take nsai; local muscle relaxant but with no improvement. now she starts to suffer from pain in rt upper arm. please your help for diagnosis and management





محمد عبد الفتاح Why the position of neck in kyphosis

**Amaly ElJana** It is due to loss of cervical lordosis

**Aliaa Omar El-hady** What is her complete cervical examination and neurological examination

**Amaly ElJana** Pain with range of motion ,local tenderness on rt side .i saw her three month ago her neurological examination was normal

**Amaly ElJana** Her mother said that no history of trauma

## **Case 65**

### **Omer Mala Ahmed**

February 29 · Ranya, Iraq

□ 16 years old Boy with Down syndrome complaining of left knee pain , morning stiffness for more than 1month , no fever , no skin rashes , no mouth ulcers, normal Eyes.

He is mentally retarded & can't give very informative history regarding preceding genital infection.

Had no history of arthritis in other joints.

□ O/E :

The knee is swollen, he can't extend the knee fully because of pain.

□ INVESTIGATIONS :

• Hb: 13

• WBC : 10.5

• Plt: 235000

• ESR:70

• CRP : Strongly positive (1/640)

• GUE: normal

• Rf :-ve

• S.URIC ACID: 9.6 mg/dl

□ We have no polarized microscope to examine the SF for Crystals.

□ Your provisional diagnosis?



**Omer Mala Ahmed** Dear profs & doctors:  
Howaida Elsayed Mansour, Amal El Ganzoury, Basant  
Esawy, Rageh M. Elsayed, Mona Mansour, Mohammed Hassan,  
....



**Howaida Elsayed Mansour** Good afternoon all, this boy is likely having ReA presented by severe inflammatory monoarthritis the most important for this boy is to rule out septic arthritis so please take synovial sample for gram stain and culture DD is gout ( but it is unusual to have acute gouty arthritis for one month without fever )...and start ttt by doxycycline 100 mg orally /12 hours for 10 days to eradicate any offending infection , hydrocortisone 5 -10 mg daily + salazopyrine 500 mg 1x3 + NSAIDS , please do slitlamp examination to rule out iritis

**Omer Mala Ahmed** Dear prof **Howaida Elsayed Mansour** for great thanks for your always golden comment, but this high Uric acid level of 9.6 mg/dl has no significance? Could gouty arthritis firstly affect the knee before any other joints?

**Howaida Elsayed**

**Mansour**<http://www.ncbi.nlm.nih.gov/pubmed/24766390>



Children with Down's syndrome display high rates of...

NCBI.NLM.NIH.GOV|BY KASHIMA A , ET AL.

**Howaida Elsayed Mansour** hyperuricemia is very common in down syndrome patients....but it is not necessarily to be the cause of his knee pain (it is usually asymptomatic hyperuricemia )...



**Amal El Ganzoury** hi dr Omer a nice case as usual. we should ask of family history of gout or metabolic disorders . try to get more information if had previous similar attack or not or other joint affection diagnostic US can be of help it may detect crystals also aspirate synovial fluid and light microscope can show crystals but not the birefringence mostly gout but we need more verification as I reported

colchicine

non steroidal

steroids are possible alternative in resistant situation.

try to extend knee fully to avoid flexion Def.

**Howaida Elsayed**

**Mansour** <http://www.ncbi.nlm.nih.gov/pubmed/24766390> - it is usually asymptomatic hyperuricemia. ..



Children with Down's syndrome display high rates of hyperuricaemia. - PubMed -...

NCBI.NLM.NIH.GOV|BY KASHIMA A , ET AL.

**Omer Mala Ahmed** It's great ☐☐☐

**Mona Mansour** Dear Dr **Omer Mala Ahmed** I suspect reactive arthritis in view of the high acute phase reactants. Please ask for history of diarrhea or dysentery. Ask also again for fresh first void midstream urine sample . Do not wait and start ttt

**Basant Esawy** Dear Dr **Omer Mala Ahmed**

My DD is gouty arthritis as dr **Amal El Ganzoury** said

But please rule out septic arthritis first either acute bacterial or chronic as TB by aspiration and analysis of synovial fluid and synovial biopsy if needed

Reactive arthritis is a DD ask for any associated symptoms

If septic arthritis ruled out IA injection with NSAIDs/ colchicine

**Mohammed Hassan** good morning dear dr omer .... for me the first dd is acute gouty arthritis then reactive arth and plz rule out septic arthritis ( normal WBCs against septic arth)..... firstly aspirate synovial fluid and analysis is the golden rule. start with Nsaids and colchicine and if rule out infection give either low dose GC or local injection

## **Case 66**

**Omer Mala Ahmed**

March 6

☐ Case :

35 years old 6 MP pregnant lady presented to me complaining of bilateral anterior hip pain for about three weeks duration , the pain increase with rest & improves with activities . No fever , No skin rashes , No personal & Family history of psoriasis or spondyloarthropathies.

She has no evidence of septic arthritis because she can walk without supports & the pain not severe & has no constitutional symptoms.

☐ O/E : limitation of internal & external rotations of both hip joints.

☐ INVESTIGATIONS :

- Hb : 11
- WBC: 9000
- PLL: 280 000
- ESR : 68
- CRP: 1/640 ( Strongly positive )
- GUE : pus cell +
- Brucella : negative
- S.Vit D : < 8 ng/ml ( Very deficient )
- S.Ca : 8.18 mg/100ml

☐ She afraid from taking injections because she had no children till now & the child very wanted .

☐ For your kind opinions regarding the diagnosis & Management ?



**Sherry Kamel** High ESR and positive CRP can be explained by URT infection

**Mona Mansour** By the way MRI is safe for pregnant women

**Tamer Elfarahaty** Dear Dr **Omer Mala Ahmed** 1) Severe vit D deficiency is one of the causes of hip pain in your patient or aggravates it ;need to be treated by oral vit D 3 4000 IU/ day with Ca 1500 mg /d with monthly monitoring of serum & urinary Ca to detect early hypercalcemia . Also check serum 25 OH vitD after month of treatment if no significant increase in vitD level ;increase dose of vit D3 by 1000 to 2000 vit D 3/day . 2) physiological high ESR occur in pregnancy but not to high level so need to think and search for underlying cause which may be explained by suggested UTI ;need Antibiotics according to urine culture & sensitivity 3) idiopathic transient migratory osteoporosis occur in last pregnancy and may continue postpartum but nature of inflammatory pain & high APR (not with it) .Also ;it commonly starts only in one hip (not affect both hips at the

same time) but sometimes after weeks may migrate to opposite hip named ( regional migratory osteoporosis). So MRI is diagnostic( if no improvement of pain) 3) ReA is one of possibilities and it can explain inflammatory nature of pain & high APR which may be sometimes self limiting start paracetamol & follow up

**Omer Mala Ahmed** Very informative comment dear Dr **Tamer Elfarahaty**, thanks alot, could Vit D deficiency cause bilateral hip pain of an inflammatory nature ( ie: pain improve with activities) ?

**Tamer Elfarahaty** It is commonly mechanical. But beside search for other causes that explain inflammatory nature of pain & high APR (i think ReA & UTI ), it is essential to correct vit D def. and follow up

**Omer Mala Ahmed** MEGA Regards for your golden information ☐



## Case 67

### Omer Mala Ahmed

March 9 · Ranya, Iraq

#### □ CASE :

□ 42 years old woman about 4 years ago presented to me with right knee pain & swelling, the knee was hot but not erythematous , not associated with fever or constitutional features, the patient could walk on it with limping, at that time i did synovial fluid aspiration & it was very turbid , so i sent it for C&S , the result was returned with isolation of moderate growth of staph.aureus !! With ++ sensitivity to Rifampicin ( believe that the Culture not dependable & every SF i sent for thi Lab the result returned with growth of Staph.aureus □ ) , I admitted the patient & i gave her Rifampicin for 6 weeks without dramatic response so i added also NSAID & i did many times SF aspirations at that time , fortunately the condition improved very slowly.

□ About 3 months ago she returned to me again with Rt ankle arthritis with swelling & pain without redness or fever .

At that time had strongly positive CRP (1/640)

I gave her 2cc Diprofos IM + Etorocoxib 90mg/day for two weeks .

After one month she returned to me & she was better for ankle arthritis .

□ But today she returned to me again with Rt Rt Ankle arthritis & swelling of MCP & PIP joints of left hand involving also the intervening soft tissue between these two joints! , the condition not associated with fever , no skin rash , no personal or family history for psoriasis , no evidence of inflammatory back pain .

#### □ INVESTIGATIONS :

- WBC : 10000
- Hb: 12
- Plt: 258000
- ESR : 35 mm /hr
- CRP: 1/640( strongly positive )

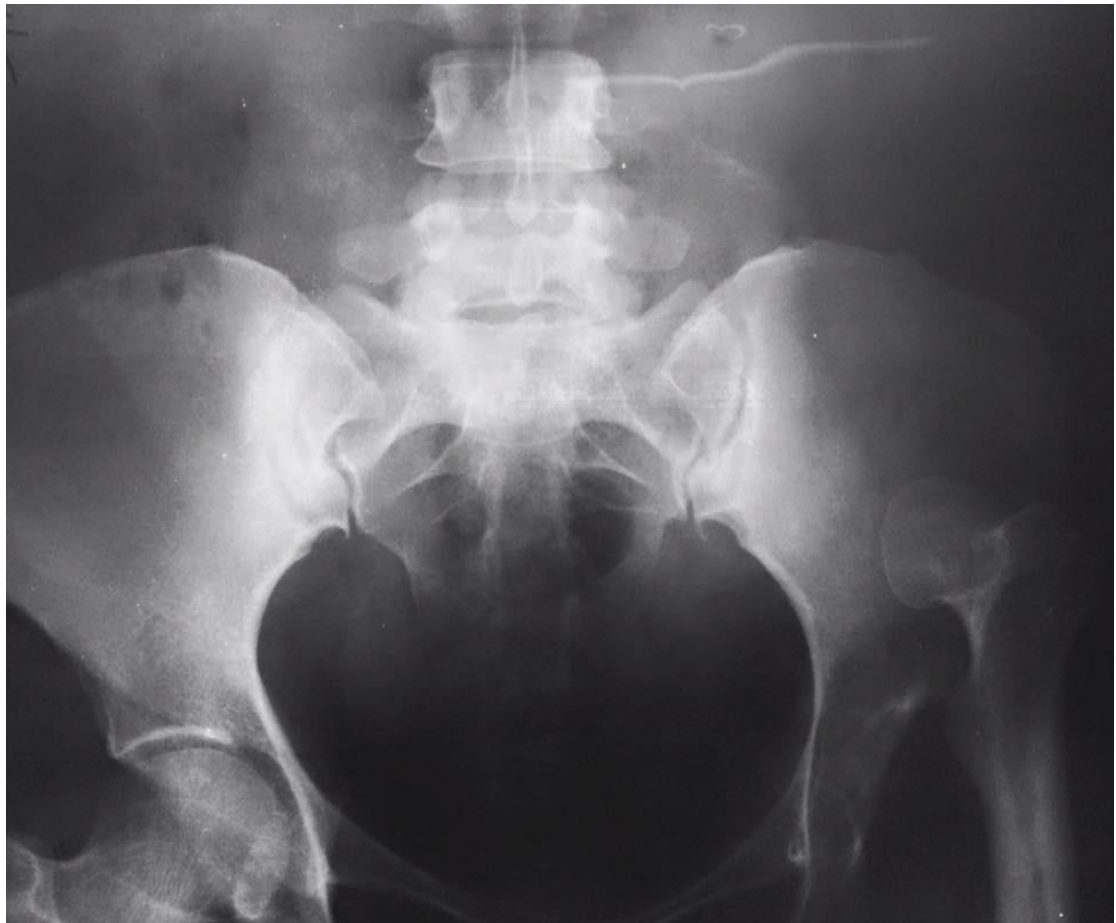
- GUE :
- turbid
- pus cells : ++
- Albumin : trace
- S.uric acid : 3.94
- RF : Normal
- LF :Normal
- Rf : negative
- Anti CCP : -ve
- SF from the ankle:
- WBC : 35.500
- C&S : pending
- CXR : Normal

□ FOR YOUR KIND OPINIONS REGARDING THE  
DIAGNOSIS & TREATMENT ?

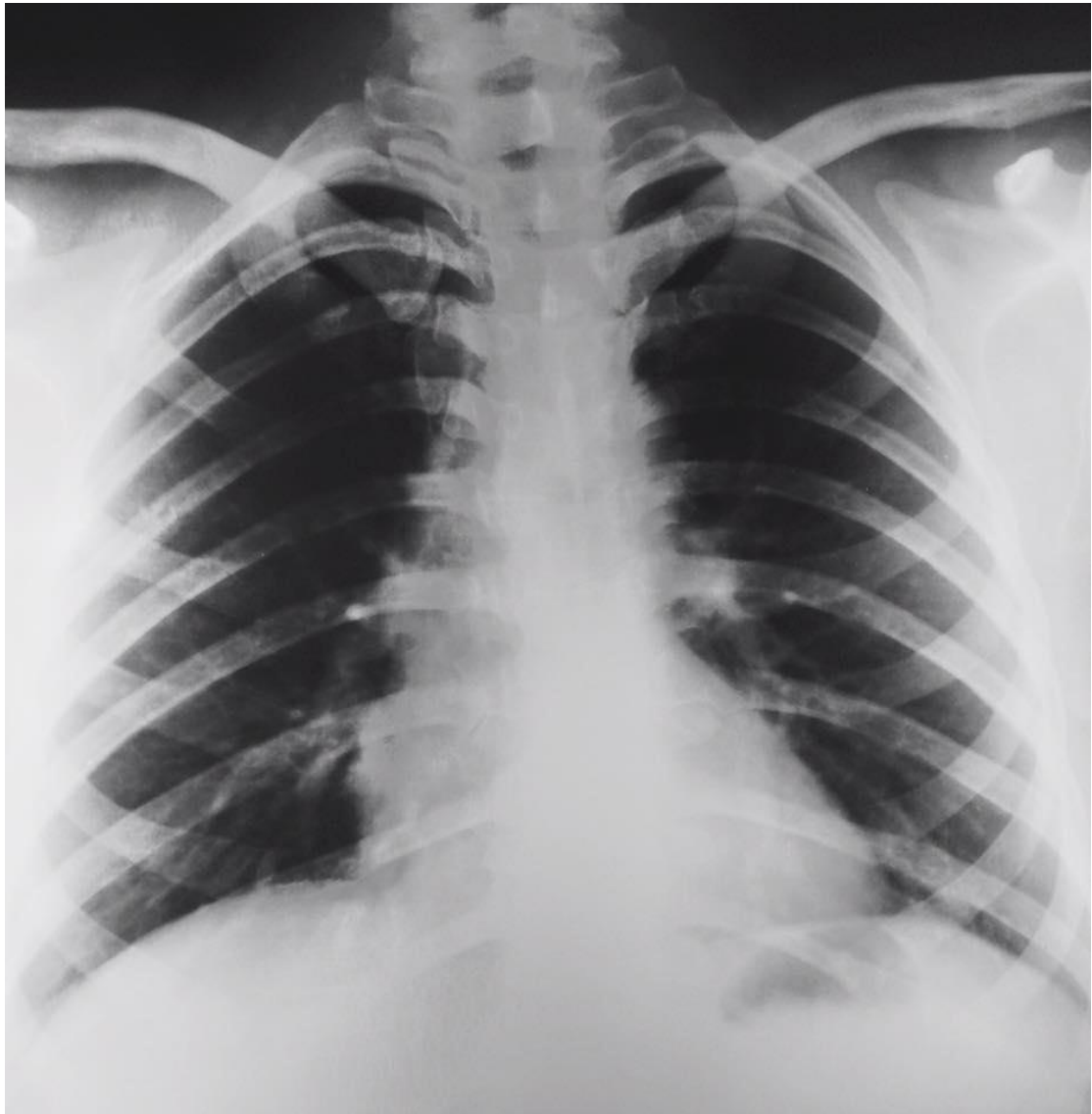












**Omer Mala Ahmed** Dear profs & doctors  
**Howaida Elsayed Mansour, Amal El Ganzoury, Basant Esawy, Tamer Elfarahaty, Mona Mansour, Fatemah Elshabacy, Rageh M. Elsayed, Sherry Kamel, Mohammed Hassan.....**

**Mona Mansour** Nice case I wonder Dr **Omer Mala Ahmed** why didn't you trust your lab?!

Please do urine culture and sensitivity. I would treat this case as reactive arthritis with doxycycline 100 MG + Rifadin 300 MG for 6 month. Also sulfasalazine (2gm/ day)

I would like to see the ultrasonographic picture of her affected joints for confirmation of the clinical diagnosis and follow up.

**Omer Mala Ahmed** Thanks prof **Mona Mansour** for your informative comment , i not trust our lab because i sent some times SF & i was sure that the condition is not septic & the result every time returned with growth of Staph Aureus □

Believe me I took the samples very carefully to avoid contamination.

I sent the SF from this ankle 3 months ago also returned growth of staph aureus !

So before starting treatment today i took another sample from the ankle & i sent for another lab to see if the results are the same ?

Here i have a problem with labs & i diagnose most of my cases clinically .

Believe me in the city that work there is no blood film ! Just we have ELISA for ANA , RF & Anti CCP ! We have no any other autoantibodies !!

Any way you see this is a case of ReA ? You advice to give Antibiotics for 6 months ? Sulphasalazine also for how long ?

Great regards □

**Mona Mansour** 6\_12 months till complete remession also methotrexate can be an option if the resonse to sz is not satisfactory

**Mona Mansour** Inadequate circumstances creates good physician □

**Omer Mala Ahmed** Thanks allot prof **Mona Mansour**

**Basant Esawy** Dear dr **Omer Mala Ahmed**

Thank you for sharing interesting cases

First you were dealing with monoarthritis in Which you did a great job by excluding septic and now oligoarticular arthritis lower limb

So my DDx in such case will be

- 1-Reactive arthritis as Dr [Mona Mansour](#) said
- 2-sarcoidosis do please chest x Ray and ACE if available
- 3-Atypical RA presentation
- 4-Less likely SLE but there is trace albumenuria ( which could be UTI related)so alb creat ratio after ttt of UTI according to culture sensitivity

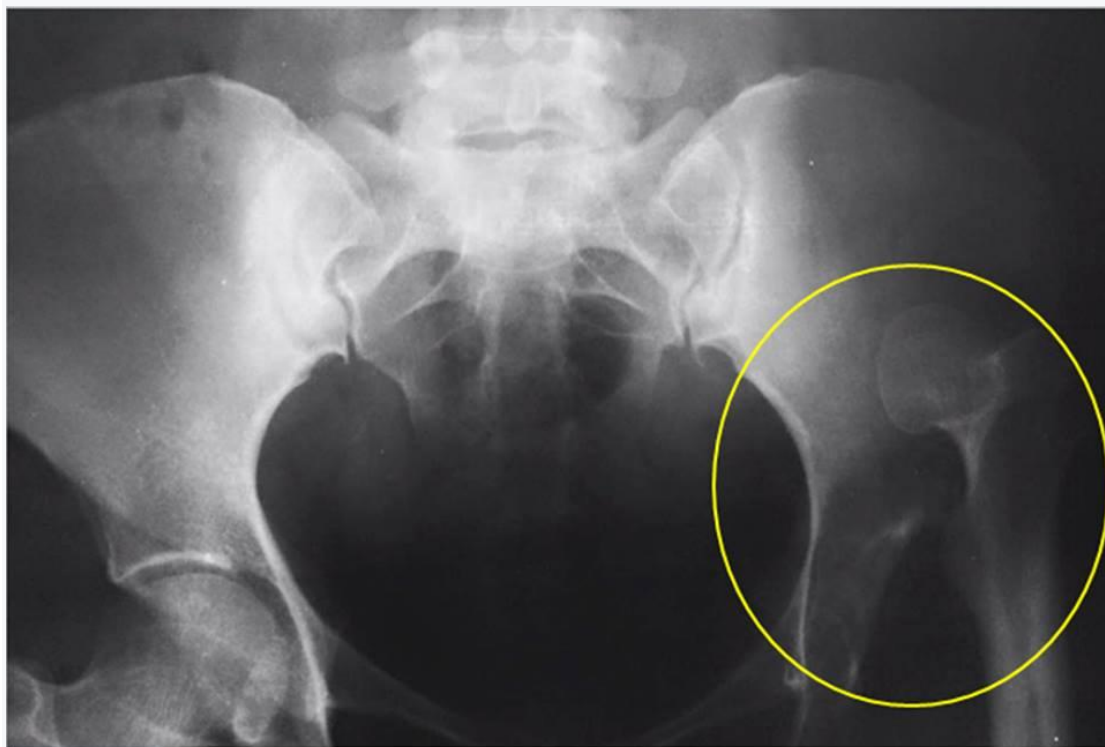
If you have got clear Proteinuria at that situation I would recommend to do ANA and DNA

So start NSAIDs and SSZ

Treat UTI with culture and sensitivity

[Omer Mala Ahmed](#) Thanks allot my dear dr [Basant Esawy](#) for your always informative comments , really i will follow your recommendations inshallah , the CXR was normal ☐

[Aliaa Omar El-hady](#) ??? dislocated hip



[Omer Mala Ahmed](#) Yes dear Dr alia has DDH from birth  
[Howaida Elsayed Mansour](#) Dear all, dear dr. [Omer Mala Ahmed](#) search for sarcoidosis/psA this finger dactylitis and tenosynovitis is the secret key of sarcoidosis /PsA even if there is no family history spescially that this lady has Asymmtrical inflammatory oligoarthritis at the rt knee/ rt ankle, please start

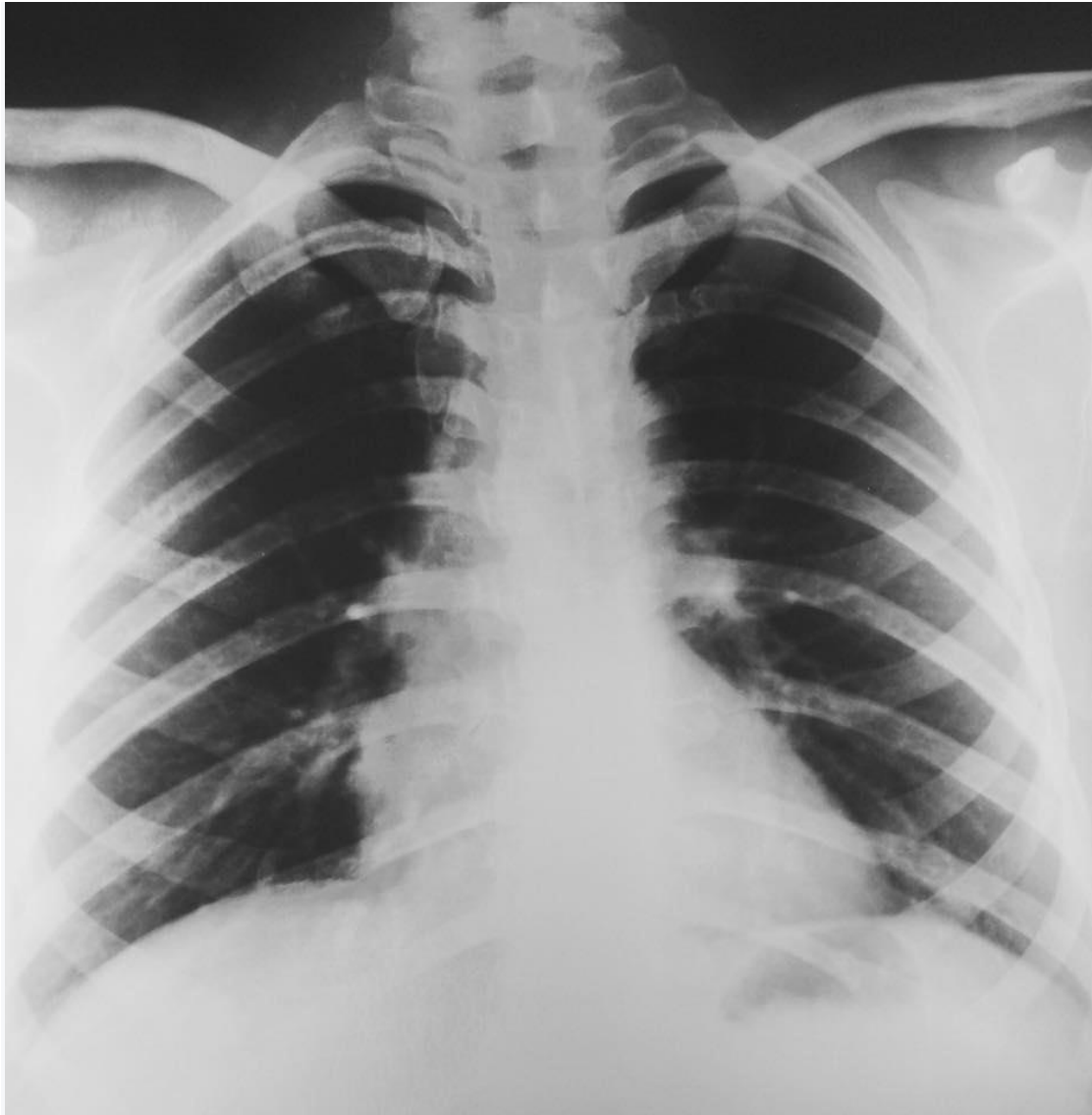
the work up of these both conditions ask for erythema nodosum (even patchy violot spots at LL), do slitlamp examination for uviitis , do HRCT chest but this is not a case of ReA ( the age and presentation) and dont wait for the results start ttt by MTX 18 mg /week sc and low dose steroids 5 -10 mg with calcium and vit D

**Omer Mala Ahmed** Thanks allot Dear prof **Howaida Elsayed Mansour**:she denied family history of SPA , SIJs on X-Ray were normal , do you prefere to do SIJ MRI ? Also CXR was normal so i should arrange HRCT chest ?

I know that the ReA & other SPAs are more commonly present in young age group but the ReA cant happen in middle aged group ? Why this presentation against ReA ? She has ++ pus cells on GUE & previously had also attacks of UTI .

From SF culture there is moderate growth of Staph aureus , can we exclude the Septic arthritis from the list of DD ? You say the case may be SPA with peripheral joint involvement ; why you prefere MTX over the SSZ ? Great regards

**Omer Mala Ahmed**



**Howaida Elsayed Mansour** Bec your pateint has "dactylitis" this is the secret key of PsA/ sarcoidosis..yes dr **Omer Mala Ahmed** dactylitis rules out septic arthritis ( but it is very rare to occur with ReA except in gonococcal arthritis) - even if there is no family history of PsA and no sacroilitis ( no need to do MRI) thats why MTX 15 - 18 mg sc is the best ttt for your pateint DD sarcoidosis so please do HRCT and slitlamp exammination

**Omer Mala Ahmed** Prof **Howaida Elsayed Mansour** if we reach that the case is SPA with mainly peripheral joint involvement still the MRI of SIJ is helpful ? If we excluded sarcoidosis still you prefer MTX over SSZ or they are the same ?



**Howaida Elsayed Mansour** 1- No need for MRI simply bec the patient has no back ache ...

2 - even after excluding sarcoidosis to me - MTX is the best DMARD bec she has dactylitis with recurrent asymmetrical oligoarthritis ...

**Omer Mala Ahmed** Thats good , thanks allot prof **Howaida Elsayed Mansour** □ □

**Tamer Elfarahaty** Dear Dr **Omer Mala Ahmed** . For me it is mostly Reactive arthritis (asymmetrical oligoarthritis ;dactylitis &tenosynovitis ) . Examine for lower limb Enthesitis or Sacroilitis . Fundus exam & HLA B27 . Ask about FH of SPA 2) urine C&S then start Antibiotics 3)Also ; Female with Ankle arthritis & dactylitis need a workup to rule out sarcoidosis . 3) start SAZ: 2 to 3gm/day &NASDs. and follow up

**Omer Mala Ahmed** Dear dr **Tamer Elfarahaty** For ReA you prefer SSZ over MTX ? Or both have the same efficacy ?

**Tamer Elfarahaty** Start SSZ . MTX is an alternative ,If no or inadequate response . If diagnosis of ReA is established & persistent or recurrent arthritis anti TNF is another option.

**Tamer Elfarahaty**

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The use of SSZ in patients with reactive arthritis is based primarily upon one randomized trial in patients with reactive arthritis [59] and is further supported by a meta-analysis and randomized trials comparing it with placebo in patients with ankylosing spondylitis and with psoriatic arthritis; and by randomized trials comparing it with placebo and other nonbiologic DMARDs in rheumatoid arthritis. We prefer SSZ over MTX because of its better documented efficacy in patients with peripheral SpA, including psoriatic arthritis. (See "[Assessment and treatment of ankylosing spondylitis in adults](#)", section on '[Sulfasalazine](#)' and "[Sulfasalazine in the treatment of rheumatoid arthritis](#)" and "[Treatment of psoriatic arthritis](#)".)

Benefit from SSZ was suggested by a 36-week randomized trial involving 134 patients with chronic reactive arthritis who had not responded adequately to NSAIDs [59]. Response in the trial was defined by a composite measure that included patient self-assessment, clinician assessment, and improvement in joint pain or tenderness and in joint swelling. Results for the primary outcome measure showed a trend toward benefit with SSZ that was not statistically significant but that might be clinically meaningful if real. SSZ was well-tolerated, with minor gastrointestinal side effects in some patients.

[Tamer Elfarahaty](#)

**Duration of therapy** — The nonbiologic DMARDs are continued for at least four months (SSZ) or three months (MTX) at the maximally tolerated therapeutic dose (up to 3 g/day SSZ or up to 25 mg/week MTX) to determine if there is a response to therapy and are then discontinued three to six months after the patients have entered into remission, with resolution of clinical signs and symptoms of disease activity. Some patients who do not respond to the initial DMARD therapy may respond to the alternative agent, in our experience; however, whether to use a second nonbiologic DMARD or to proceed directly to the use a biologic agent in such patients has not been formally evaluated. If disease recurs, we resume therapy with the previously effective agent.

[Rageh Elsayed](#) Good pm dear Drs sorry belated thanks dear [Omer Mala Ahmed](#) for your case .  
to me acase of oligoarticular inflammatory arthritis wide wide range of DD  
Iam with our Drs in the diagnosis ReA ‘  
sero negative RA (my first possibility )  
sarcoidosis work up to reach the diagnosis and by time more signs and symptoms will appear now the best is MTX as severe arthritis presentation with CS and vitD Plus ca plz uptodate us with your requested investigation good luck



**Mohammed Hassan** Sorry for delay dear Dr omer  
 I think the main DD reactive arthritis then sarcoidosis plz for  
 ophthalmological examination and serum Ace and serum  
 calcium and uric acid and HRCT chest till this manage as re arth  
 with MTX 20 mg/wk and low dose steroids + ca and vit D  
**Omer Mala Ahmed** Dears all , Update regarding this case :  
 After i aspirated the SF from the inflamed ankle & i sent for C&  
 S , the result returned as follow !!!!  
 For your last advices please

| Bacteriology                                                                                                                                                      |      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|
| Sex: female                                                                                                                                                       | Age: |
| Sample test: synovial fluid culture                                                                                                                               |      |
| Result test: Growth of pathogenic micro-organism undiagnostic<br>gram positive Bacteria, because it needed biochemical test for<br>diagnosis of types of bacteria |      |

|                 |     |
|-----------------|-----|
| Ciprofloxacin   | +++ |
| Nitrofurantoin  | R   |
| Norfloxacin     | R   |
| Gentamicin      | R   |
| Doxycycline     | R   |
| Amikacin        | ++  |
| Ceftriaxone     | R   |
| Cefixime        | R   |
| Nalidixic acid  | R   |
| Chloramphenicol | +   |
| Rifampin        | ++  |
| Azithromycin    | R   |
| Trimethoprim    | R   |

Note: Sensitive: (+) Resistant: (R)

**Rageh Elsayed** The presentation never goes with septic arthritis  
 something wrong  
**Omer Mala Ahmed** What you say dears profs & doctors  
 regarding this case after the result of culture which i don't know

if it correct 100% or not because we have just these poor quality labs . But i saw the SF was very turbid yellow color

[Howaida Elsayed Mansour](#), [Basant Esawy](#), [Tamer Elfarahaty](#), [Mona Mansour](#) ,[Mohammed Hassan](#)...

[Basant Esawy](#) I am totally agree with dr [Rageh M. Elsayed](#)

This presentation does not go with septic arthritis

Plus the lab did not specify the type of organism only gram positive which is not acceptable, it should be specifically mention the organism and its counting then sensitivities , I think this is contamination

[Mona Mansour](#) Turbid fluid could be found In septic as well as gout and cppd. Depend on your clinical sense and follow up the case closely

[Howaida Elsayed Mansour](#) To me dr.[Omer Mala](#)

[Ahmed](#) Inflammatory oligoarthritis + finger dactylitis after ruling out sarcoidosis/PsA (conditions famous to cause dactylitis ) DD is gonococcal arthritis. ... and this goes with the lab .....!!

this time I will respect the lab.. bec simply it goes with clinical presentation ...and also you said SF was very turbid. ..

gonococcal arthritis is commonly cause Asymmetrical finger dactylitis... + urine + ve pus cells ... so to me I'll start penicillin injections for 10 - 15 days alone only with NSADs (to confirm the diagnosis) but if arthritis persists you may start DMARDs for 2 - 6 months...

[Howaida Elsayed](#)

[Mansour](#) <http://emedicine.medscape.com/article/333612-differential#1>



[Gonococcal Arthritis Differential Diagnoses](#)

EMEDICINE.MEDSCAPE.COM

[Omer Mala Ahmed](#) Great thanks for all of you , You gave me the way to how manage this difficult case ☐☐

[Howaida Elsayed Mansour](#) Updates us by the results

[Omer Mala Ahmed](#) Inshallah dear prof [Howaida Elsayed Mansour](#)☐ [See Translation](#)



## Case 68

**Abdelrahman Amer**

March 11

Thanks to dr **Alaa Ali Awad**

Female patient aged 47 years

- Complaint:Multiple painful skin lesions & generalized bone ache for five years
- condition started 5 years ago with gradual onset & progressive course by numbness& tingling of both hands followed by ms weakness & heaviness in both UL & LL ... she couldn't rise from bed ,comb her hair , raise her hands , eat by herself or stand from sitting....almost bed ridden for 1y
- That condition followed by hard painful skin lesions in abdomen w increase in size ,then spread in multiple sites in shoulder , buttocks, back, thigh.
- Patient take ttt MTX& steroid 20 mg....that was followed by improvement in ms power but skin lesions increasing
- The condition is also associated with:

- Fatigue arthralgia
- Planter fascitis
- Ms cramps
- MS 1 hr
- Night pain
- No oral ulcers, no malar rash ,no photosensitivity, no alopecia
- NO increase in body temperature , NO night sweating
- dyspnea, chest pain , no cough .
- Anorexia, heart burn , dysphagia , no haemotysis
- Palptation, blurring of vision.
- Weight loss
- Low back pain & cx pain w incrase by effort
- No change of bowl habits or dysuria.
- No vaginal discharge or genital ulcers.
- NO CHANGE OF FINGER COLOURS.

- No DM
- no hx of swelling of any joint

Drug Hx.

MTX 25mg \ week & solupred 20mg/d for 5ys

- examination shows

- Normal ms.reflexes

- .Normal ms power

- Inspection:

- .Multiple indurated skin lesions on both thigh , buttocks , knees ,upper arm , shoulders , low back

- .No nail changes

- Palpation:

- .Those lesions are hard , tender , skin is tight over them

- .No sclerodacty

- .Creptus on both knees

- .+ve tender points for FMS

- .There is no arthritis , just arthralgia especially elbows

- .Normal ms.reflexes

- .Normal ms power

- FUNDUS : bilateral normal fundi

- bilateral blepharitis

- Lab. Investigations:

- CBC: WBC:6.7 RBC:4.50 HGB:14.0 MCV:92 MCH:31  
PLT:215

- ESR :20 (2016) 75(2014)

- CRP:-ve

- RF:-ve

- S.Ca: 9.1 mg\dl ( RR 8.5-10.

- S.Ph: 4.3 mg\dl ( RR 2.5-4.5)

- S.PTH: 55.0 Pg\ml ( RR 12-72)

- S.CK: 93.2 U\L (<127)

- LDH: 458 mg\dl (RR 240-480))

- ANTI HCV Ab: -ve

- ANTI HIV Ab: -ve

- HBsAg: -ve

- ANA: -ve
- ANTI Ds DNA: +ve
- ASO: -ve
- Anti Scl 70 Ab: -ve
- S.creat: 0.8
- S,albumin: 4.3
- S.bilirubin: 0.8
- AST: 20
- ALT: 21
- Random Bl. Sugar: 108 (<200)
- S.C3:1.32 ( RR0.9-2.1 g\dl))
- S.C4:0.16 ( RR 0.1-0.4))
- S.ALPHA FETO PROTIEN : 1.2 ng\ml (<10)
- S.CEA: 0.4 ng\ml (up to 2.5)
- S.CHOLESTEROL :255 mg\dl (<200)
- S.triglycride:103 mg\dl ( RR <200)
- S.URIC ACID: 3.5 mg\dl
- Radiological investigations
- HRCT chest : Free
- ECHO: NORMAL
- X-ray Hand & Feet : free
- X-ray CHEST : Free
- X-ray thoracolumbar
- X-on hip joint : calcifications in abnormal sites
- EMG (2012): Myopathic affection of proximal ms.  
Electrophysiological findings not diagnostic to dermatomyositis.
- EMG (2016): NO EVIDIENCE OF myopathic, neuopathic, myotonic manifestations.
- NCV : mild lt CTS
- DOPPLER US : patent deep & superficial venous system of pelvis & both LL .. No DVT or superficial thrombophilipitis
- Skin biopsy: 3 different !
- Skin biopsy from lesion on the back : consistent with diffuse systemic sclerosis

- Skin biopsy from lesion in the ant. Abd. Wall : Picture of fat necrosis with panniculitis .. No malignancy or specific lesion
- Skin biopsy from lt. gluteal mass: Picture of tumoral necrosis



what is DD? *grin emoticon*











**Tamer Elfarahaty** Dear dr **Abdelrahman Amer** thanks for sharing this challenging case 1) Biopsies results are not consistent with clinical finding . a) diffuse SS : there are multiple indurated skin lesions with radiological calcinosis but ( non involvements of skin of fingers ; no raynadu's ; negative ANA ;anti SCL 70 & HRCT withn normal ) are against SS b) Tumoral calcinosis is mostly painless with history of renal failure or dialysis and with more huge radiological calcinosis . Differential diagnosis include also dermatomyositis :history of proximal muscle weakness ( normal muscle power currently) & radiolgal calcinosis but with normal Muscle enzymes ,normal EMG &no spesific skin lesion which are aginsit myositis ). Any myositis associated or spesific aut ab were done ? Muscle biopsies at time of muscle weakness ? . Postive tender points of FMS with high ESR may mean secondary FMS with underlying systemic disease or undifferentiated connective tissue disease ( arrange thyroid function test & anti URNP) . Also scleroderma mimics (scleredema & eosinophilic fascitis ) are one of possibilities especially with skin induration sparing fingers ; absence of RP and auto antibodies . U Need expert histopathologist for skin & fascia biobsy .

**Like · Reply · 2 · March 12 at 1:26am · Edited**

**Abdelrahman Amer** Dear dr **Tamer Elfarahaty** thank you for this excellent analysis smile emoticon no ms biopsy was done ..no specific Ab for DM was done ..i will ask for anti-RNP ..thyroid FT

**Omer Mala Ahmed** Dear dr **Abdelrahman Amer** thanks for sharing this interesting & vague case , this patient has not fulfill criteria for systemic sclerosis .

So we should think about other diseases which may be rheumatological or dermatological .

What about Differential WBC count ? For measuring peripheral Eosinophil count that they increase in Eosinophilic fasciitis which is one of the DD in this case .

Also i advice to do a Dermatologists consultation to take their idea .

Reading of the biopsy by another perfect histopathologist also mandatory .

**Abdelrahman Amer** Thank you dr **Omer Mala Ahmed**.. i will ask for DLC ..biopsy

**Omer Mala Ahmed** Dear Dr **Abdelrahman Amer** still there is possibility of SLE with paniculitis , because the lesions just like paniculitis .

(Thickened and firm nodules and plaques  
Erythematous or pigmented overlying skin

It is often painful or tender

Sometimes, lesions

resolve to leave localised subcutaneous atrophy (lipodystrophy),

- Also please repeat the ANA by IFT , because its not worthy to have positive Anti-dsDNA with negative ANA !! The ANA like a mother & Anti ds-DNA is part of ANA & like a child , so child without mother is absolutely not possible . Also send for Anti-Ro which may be positive in ANA negative cases.

- If SLE Excluded then we can say its idiopathic Paniculitis which also presents typically with paniculitis skin lesions , this

condition may be associated with mild fever , fatigue & arthralgia .

- To me this case in the future will get more benefit from steroid & HCQ rather than MTX & Steroid.

**Tamer Elfarahaty** Yes ;SLE ( may meet criteria later on) or undifferentiated CTD (need follow up) are possibilities but Different results of biopsies are non dependable . Third biopsy result show just panniculitis without specific picture consistent with SLE or other diseases ( eg: lobular or septal or both ). Many causes of panniculitis ; each of one has specific clinical picture ;site and biopsy . Also lupus profundus is more nodular & lobular or depressed than in shared pictures and occur more in extremities & face . No symptoms or sign &lab suggest SLE although Lupus profundus (but with specific biopsy) may precede SLE by years. Panniculitis also occur with FMS as fibrotic nodules (paraspinal fat herniation ) near site of tender points. So i think need dermatological consultation & expert histopathologist . For ttt as patient on steroid for long time and also for calcinosis add bisphosphonate .

## Case 69:

### **Dalia Hussien Kamel**

19 March

75yrs female pt diagnosed as RA since 6yrs, received mtx 4yrs & then stopped ttt for 2yrs, she came e' MS for 1/4hr & synovitis of 2 MCPs, severe tenderness of bilateral wrist, all MCPs, all PIPs (she pulled her hands)

Erythema appeared on malar eminences, nose of one month duration

No alopecia, oral ulcers

Dry eyes but no rh nodules

No hx of psoriasis

Invest.

ESR 29. 1st. hr

CRP-ve

RF 32

ANA+ve since 2yrs when repeated recently by IF was - ve

A/C ratio - ve

HBV & HCV - ve

ALT 7

AST 9

S creat 1.1

ECG free

What about diagnosis? RA??













**Dalia Hussien Kamel** Dr. Aliaa Omar El-hady  
**Aliaa Omar El-hady** Ask for uric acid... DD. Pseudogout..  
Gout..nodal OA



**Omer Mala Ahmed** Dear Dr **Dalia Hussien Kamel**  
In 75 years old female patient we should think about  
CPPD & Nodal OA more than any other types of arthritis.  
In this case the affection of wrists not going with Nodal OA  
.  
Affection of wrists & MCP joints means it's more likely  
CPPD .

**Dalia Hussien Kamel** Thanks for ur kind explanation  
dr **Omer Mala Ahmed** so,we diagnose CPPD by exception  
there's no invest.to confirm it? What about its  
managment?why this severe tenderness on pt hands?no  
erosions in xray? The active synovitis more in MCP, wrist  
tenderness only, that also against OA right?



## Case 70

**Gehad Adel**

19 March

plez whats your opinion in that case ?????

female pt, 16 years old with polyarthritis of both wrists, elbow ,ankles and knees of 2 years duration associated with low grade fever of 3-5 days recurrent every 1-3 weeks with past hx of recurrent attacks of tonsillitis and tonsillectomy was done 6 years ago  
echo was done 2013 and show : (Rheumatic heart disease

, mitral valve prolapse with mild mitral valve regurgitation and mild tricuspid valve regurgitation)

the following investigation was done

ESR 104/ 119 mm/h

CRP 48 mg/l

ASOT –ve

Hb 8.83 g/dl WBCs 8.80 K/UL PLTs 429 K/UL

MCH: 23.3 Pg ( 24.8: 30.2) MCV : 72.7 fL (76.7: 90.6)

(microcytic hypochromic anemia)

KFT: Normal

LFT: normal

RF 128 IU/ ml

ANA : 1.1 AI

Anti-CCP 1.2 U/L

Urine analysis: normal

Abdominal US : normal

Fundus examination: normal bilaterally

note that RF is recurrent 3 time in last 2 years and reveal 128 IU/ ml

by examination :

pt has polyarthritis of rt wrist, knee and ankle and tenderness on left side

pt diagnosed as JRA ?????

and run on MTX 15 mg/ day , hydroxyqlurochine 400 mg  
and steroid 15 mg / day  
these are the following x-rays







**Aliaa Omar El-hady** Any history of rash ?? What about s. Ferritin, I think it is a case of Still's dis.

**Gehad Adel** No hx of rash

**Gehad Adel** Serum ferritin not done

**Mona Mansour** Consult cardiology to exclude subacute bacterial endocarditis and do blood culture. Also fever chart recording is important in d.d

**Gehad Adel** We made consult cardiology and asked echo (bending )

**Gehad Adel** What about interpretation of high titre of Rf ??? And ANA is border line

**Mona Mansour** Then ask for the blood culture.

**Omer Mala Ahmed** Thanks for sharing this interesting case dear dr **Gehad Adel**

To me the case is not Rheumatic fever because the arthritis of ARF is migratory & usually it resolve after few weeks of acute attacks even untreated.

The DD remains between the pJIA & sJIA

**Gehad Adel** Is it coexist with valvular affection of RHD ?? And need for long acting penicillin ??

**Gehad Adel** With her usual ttt

**Gehad Adel** Or is it acarditis of SJA

**Gehad Adel** This case was presented in front of our staff of rheumatology department and they confirm that she is RF+ve polyarticular JIA plus rheumatic heart disease due to valvular affection by ech ( mild mitral & tricusped valve regurgitation with mild mitral prolapse ) for continue on MTX full dose 25mg/weeks and full dose of NSAIDs and if need IAS can be done with continue on LAP as aprophlaxis of ARF

X.rays of pt show ( carbal bone affection ; narrowing, sclerosis, erosions, jaxta- articular osteopenua and periosteal reaction & bil compartmental knee joint space narrowing & bil narrowing and sclerosing of hip joint with coxa varus un on side more than other ) patient reveal destructive polyarthrititis of JIA with RF positive and at the same time we cant ignore the valvular affection by echo of RHD

**Aliaa Omar El-hady** thank you for this interesting case ... good thinking

**Abdelrahman Amer** Thank you for this nice case ...keep up👍👍



## Case 71

**Mohamed Magdy**

27 March - Cairo

عندي حالة كويصة وخصوصا أنها أخصائية علاج طبيعي  
Female pt 35 ys old presented with generalised bony  
. ache with tender points of fibromyalgia also present  
المريضة كانت جاتلي من حوالي ٣ سنين وكانت عاملة تحاليل وكانت كالاتي :  
ANA : positive with low titre  
Anti-dsDNA : negative  
C3, C4 : negative  
ESR : 60  
فيه حد كان شافها وقالها انت كده SLEE ، المهم سمعت عني وجات لي العيادة ،  
فحصتها كويس ، كل اللي كان عندها  
Tender points of fibromyalgia , with fatigue especially with  
، effort  
سألته أسئلة كثيرة  
، For exclusion of Reactive arthritis and spondyloarthritis  
وبالفعل عملت استبعاد ليهم كلهم  
شكيت على طول أنها ممكن تكون autoimmune thyroiditis  
وبالفعل طلبت  
Antithyroglobulin , antiperoxidase , ASMA  
وبالفعل طلخوا عاليين عدا ASMA كان normal  
TSH : 10  
طلبت أيضا US on neck وكانت النتيجة element of thyroiditis  
كان تشخيص للحالة حينئذ autoimmune thyroiditis with secondary  
fibromyalgia  
بدأت العلاج كالاتي :  
Eltroxin 50mg  
Azathioprine  
Steroid 40 mg  
Lyrica 75 + ca +vit D  
المريضة أخذت العلاج وبدأ فيه تحسن نوعا ما ، وبدأنا نعمل withdrawal for  
steroid لحد ما وصلنا ل ٥ mg ، الكلام ده في حوالي سنتين .  
المهم في السنة الثالثة العيانة وقفت الأدوية تماما ، بعد ما عملت التحاليل ولقيتها  
سلبية  
العيانة افكرتني الأسبوع اللي فات وجات بنفس الأعراض القديمة ، صراحة كانت

عندنا رسالة ماجستير في القسم

Relation ship between vitamin D deficiency and  
fibromyalgia

وبالفعل طلبت للعيانة vitamin D , PTH , DEXA وكانت المفاجأة أن

Vitamin D : 5 , PTH : normal, DEXA : show osteopenia  
especially in the distal radius

Antiperoxidase : high

صراحة خطة علاجي كانت كالآتي :

Eltroxin 50

Sterogyl600,000amp

Calcium

Cymbalta 60

Carnvitaforte tab

مستنتي آرائكم مع جزيل الشكر

**Mustafa A Elmenawy** 🙌👍👍👍

**Mohammed Hassan** nice case dear dr mohamed magdy  
there's close relation between vit D levels and  
autoimmune thyroiditis

**Mohammed**

**Hassan** <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3921055/>



Vitamin D Deficiency and Its Association with Thyroid  
Disease

NCBI.NLM.NIH.GOV

endocrine هو تعليقى الوحيد يا دكتور ان الحاله لازم تكون متابعه مع حد  
و عندي استفسار ليه حضرتك وصفت eltroxin عشان تطيبط جرعة ال  
للحاله فى الاول steroid

**Shereen Derbala**

steroid 40mg انا عندي نفس التعليق ليه

## **Case 72**

**Gehad Adel**

29 March

Female pt 20 years old with SLE , steroid dependent, 2 month ago, she received intra articular knee injection and run on deltiazen (long acting steroid) pt complain of It knee pain and locking of her knee cant extend her knee up to 2 day duration, her x.ray reveal knee joint space narrowing with small bone like psudo joint in rt knee,  
The answer know, what we can do for her knee joint destruction and locking of her joint and what about this small bone.



Aliaa Omar El-hady history of trauma??.... I think to first to unlock the knee do arthroscope with lavage

د. أحمد يحيى إسماعيل

10 April



## Case 73

د. أحمد يحيى إسماعيل

10 April

What is your management regarding treatment plan?  
Would we start cyclophosphamide pulse?

UP 10 folds

AVICOR

PATHOLOGY DEPARTMENT - NEPHROPATHOLOGY UNIT

P.N: 330A/2016  
K.N: 330A/2016

**RENAL BIOPSY PATHOLOGY REPORT**

Patient's name: سلوى ابو الخير عبد الله  
Referred by: O.P.  
Clinical data: SLE with Proteinuria.  
Previous diagnosis: N/A  
Nature of the specimen: Renal needle biopsy.  
Date specimen received: 3/4/2016

Age: 28Y  
Sex: Female

Stain(s): HSE and Masson's Trichrome.

**GROSS:** Three cores of needle biopsy specimen; totally submitted and serially sectioned.

**MICRO:** Microscopic examination reveals three cores of renal corticomedullary tissue. Nineteen glomeruli are detected; one of which is obsolescent. The tufts are within normal limits as regards cellularity and capillary basement membrane thickness. Five glomeruli show early segmental sclerosis. The tubules show marked hydropic degeneration with some hyaline cast formation. The interstitium shows edema, patchy mild fibrosis (involving about 10% of cortical area) and mild to moderate lymphocytic infiltration with some neutrophils and eosinophils. Arteries and arterioles and JGA are normal.

**DIAGNOSIS:**  
RENAL NEEDLE BIOPSY:  
- LUPUS NEPHRITIS CLASS III-S (CHRONIC).

*Handwritten notes:*  
SLE, antiphospholipid.  
Biopsy (2012) was class I  
Now, generalized anasarca  
ESR: 125 - Recent DVT  
C<sub>3</sub>, C<sub>4</sub>: NAD S. alb: 1.5 creat: 0.8  
24h. urine ptn: 5 gm  
TTC (Current): 40 mg prednisolone, Azathioprine 50x2  
Hydroxychloroquine 200x2  
+ACE-i, statin, aspirin, Calcium

Prof. Dr. Sawsan Fadda  
Dr. Wael Hamza

د. سوسن فهد  
د. وائل حمزة

### Aliaa Omar El-hady

.... لازم biopsy حضرتك مفيش حد بيعالج حالة من تقرير اشعة ولا معمل ولا تعطى تاريخ مرضى وفحص وفحوصات المريضة ثم تطلب لها علاج

د. أحمد يحيى إسماعيل

أنا كاتب ملخص الحالة في الصورة

د. أحمد يحيى إسماعيل

رأي حضرتك د. علياء

د. أحمد يحيى إسماعيل There are 2 conflicting issues.

First is her severe edema , hypoalbuminemia and proteinuria.

Second is the chronicity in biopsy and the lesion being focal and only segmental.

Yara Tawfik I think she in a bad need for aggressive ttt

If she is young , child bearing period so pulse steroid and,mmf 3grams

If she is old , or had children , start pulse steroid,with endoxan , and,monitor for remmission

و الله أعلم

Aliaa Omar El-hady Omer Mala Ahmed- Howaida

Elsayed Mansour- Mohammed Hassan- Mona

Mansour- Sherry Kamel

Yara Tawfik

طب لايك لمحاولتى طيب 😊 □

Aliaa Omar El-hady Glucocorticoids plus either cyclophosphamide IV or mycophenolate mofetil orally for induction in patients with ISN class III disease....

Administer ACE inhibitors or angiotensin-receptor blockers because proteinuria is > 0.5 g/24 h ....

**Abdollah Gamal** 1-High chronicity index means that she is less likely to respond to ttt  
2-Usually the biopsy may contain mixed pathology as tow different classess i.e it is not 100% specific .  
3- repeat biopsy is required if not responsive to ttt  
4-Aggressive ttt should be initiated immediately to protect against further loss of nephrones :  
Immediate methylprednisolone 1 G for 3 days  
then taper dose to 60 mg day or 1-2 mg /kg /day  
followed by MMF 2-3g /day for 6 months for induction of remission. Or:  
CYC pulse 15 mg /kg Either by NIH protocol 1 g / month for 6 months or 500mg /week for 3 months (Euro protocol )  
if not responsive to cyc shift to MMF and vise versa

**Abdollah Gamal** full dose ACE i is a must and the Pt. should be monitored with 24 h ptn, anti ds DNA titre, C3 ,C4, CH50 and ESR

**Abdollah Gamal** Of course Do not forget full anticoagulation with LMWH 2mg /kg/day tow divided doses for 5 days and Warfarin with target INR 2-3 because This pt is at very high risk of both arterial and venous thrombosis due to :

- 1- APL
- 2- SLE associated thrombophilia
- 3-loss of anti thrombin III in urinary proteins
- 4- Hyperlipidemia
- 5- associated vasculitis and corticosteroid ttt

**Mona Mansour** Immediate induction aiming for remission is mandatory as our colleagues mentioned but I would like to measure complement and anti ds DNA titer, Bp, Pr/create ratio and CBC for follow up u can give mmf if she did not complete her family or give her leuprolide before I cyclophosphamide and mensa with adequate hydration. Arrange for duplex for follow up of DVT

**Hithem Omran** Completely agree with dr [Abdollah Gamal](#)



**د.أحمد يحيى إسماعيل** As mentioned creat. BP , C3 , C4 are normal. Proteinuria 5 gm /day.

**د.أحمد يحيى إسماعيل** She is on long term Warfarin therapy.

**د.أحمد يحيى إسماعيل** The problem is that biopsy is class III S - C & EULAR-EDTA guidelines mention immunosuppression in class III only if A , A/C or with class V

**د.أحمد يحيى إسماعيل** Joint European League Against Rheumatism and European Renal Association–European Dialysis and Transplant Association (EULAR/ERA-EDTA) recommendations for the management of adult and paediatric lupus nephritis:3. Indications and goals of immunosuppressive treatment in lupus nephritis (LN)  
3.1. Initiation of immunosuppressive treatment should be guided by a diagnostic renal biopsy. Immunosuppressive agents are recommended in class IIIA or IIIA/C ( $\pm$ V) and IVA or IVA/C ( $\pm$ V) nephritis, and also in pure class V nephritis if proteinuria exceeds 1 g/24 h despite the optimal use of renin-angiotensin-aldosterone system blockers

**Basant Esawy** Totally agree with my colleagues you should complete investigation

You should treat aggressively

The tubular affection and fibrosis goes with sever and chronic

But the presence of cellular infiltrates and neutrophils goes with activity

No thrombosis in the arteriolar or venules will rule out chronic thrombotic micrangiopathy of APS

So I would better say active/chronic class III

That's means she will get benefit of induction therapy with pulse steroid and cyclo vs MMF as discussed in previous comments

If she has got the DVT on warfarin you should increase

the therapeutic range to 2.5 up to 3.5

And add aspirin

**Basant Esawy** Did they do electron microscope and immunofluorescence to detect full immune house with immunoprecipitation ( IgG IgM IgA and C1q, C3c4)

**د. أحمد يحيى إسماعيل** No EM or IF dr. **Basant Esawy** will it change the decision in a patient already known lupus?

**Basant Esawy** No it will not change way of management, but heavy immunofluorescence precipitation goes with active acute condition which simply the first to disappear after steroid and immunosuppressive treatment

**Mohammed Hassan** - Start aggressive with pulse GC plus CYC or MMF as induction

- increase AZA to 150 mg/d
- increase warfarine with INR kept 2.5:3
- add vit D
- AND Complete your inv plz

**Abdollah Gamal** 1- First of all, the calculation of activity and chronicity indices are no longer used universally due to more recent literature which shows mixed predictive value of using such a score .

( ACR did not consider this calculation in its recommendations);

Refer to

: <https://www.ncbi.nlm.nih.gov/.../PMC3.../pdf/nihms393854.pdf>

2- Consultation of nephrology expert is highly recommended as this case should be managed typically with multidisciplinary approach.

3- I think this sample is unreliable and we can not make our decision accordingly because there is only 19 glomeruli in the specimen which represent an absolutely insufficient number of glomeruli to make the classification as most of experts consensus agree that; -and I quote- :



"An important issue is the accuracy of diagnosis. Focal proliferative LN is defined as fewer than 50 percent of glomeruli being affected on light microscopy. However, the accuracy of this determination may be limited by the potential for sampling error induced by the relatively small number of glomeruli that are obtained on a typical percutaneous renal biopsy. It has been estimated that as many as 100 glomeruli may be necessary to be confident that focal disease is truly present."

"Uptodate website"

3- Also bear in mind that histological samples may not correlate with clinical picture.

4- As mentioned earlier, in my opinion, Aggressive management with raising INR to 3.5 is still of choice and not to repeat the biopsy is recommended for merely technical purposes;

A- Due to lack of experienced practitioners for performing and interpreting renal biopsy.

B-Also the pt, is already anticoagulated raising the risk of either hge or DVT in case of discontinuation of anticoagulant ttt on biopsy repetition .

c- As a therapeutic test.

5- In case of both CYC and MMF failure try plasmapheresis followed by Cyclosporin 2mg/kg/day or Rituximab 375mg/m<sup>2</sup> on days 1 and 15 as adjunctive or monotherapy.

6- Do not forget bisphosphonate if she is going to continue on > 7.5 mg prednisolone for more than 3 months.

Thanks for your patience 😊:)

**Omer Mala Ahmed** Thanks for sharing this interesting case dear dr Ahmed

Really iam totally agree with the opinions of my colleagues to start immediate aggressive therapy with 3 pulses of daily 1gm MP plus monthly pulses of cyclophosphamide for 6 months with keeping her on MMF 2gm/ day .

Regarding the chronicity yes it's very unlikely to respond to therapy but from the biopsy still there's signs of active inflammatory reactions that they can be stopped by the above aggressive, so what can do if we not give the above treatment? Letting the disease to burn the remaining glomeruli ? I think it's very necessary to start the above aggressive therapy with repeating Renal biopsy after completing the 6months of cyclophosphamide therapy to see the results, if got benefits it means we should continue on MMP or 3monthly Cyclophosphamide pulses for upto 2 years.

I addition we should also start Heparin & warfarin for her DVT

Also need ACE inhibitors .

**Sherry Kamel** Good morning all, Yes dr. Ahmed, your Patient has very agresive LN,so you have to start agresive treatment AS our colleagues mentioned, to save any renal tissue.

Please consult nephrologists to followe up ur patient with you..... Good luck

**د.أحمد يحيى إسماعيل** Thanks all but Dr. **Omer Mala Ahmed** I have 2 issues in your comprehensive nice response. 1st how to keep on MMF while on endoxan? They are alternatives. 2nd is measurement of response , I think it is by labs a d clinical response not by repeating biopsy. What do you think?

**د.أحمد يحيى إسماعيل** Adequacy of Tissue Sampling

Sample size – two cylinders with a minimal length of 1 cm

and a diameter of at least 1.2 mm are needed.

Needle gauge: 18 gauge (G).

Number of glomeruli for adequate diagnosis:

For glomerular lesions: 5.

For tubulointerstitial lesions: 6-10.

For transplant kidney: 7.

د. أحمد يحيى إسماعيل That's the reference

: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3741965/>



Basics of kidney biopsy: A nephrologist's perspective

NCBI.NLM.NIH.GOV

د. أحمد يحيى إسماعيل A total of 219 biopsies were performed and only 74 were included in this review. About one-third of the biopsies (n = 25) were performed on patients with lupus nephritis and two-thirds (n = 49) on non-lupus nephritis patients. Sixty-seven specimens were considered adequate and only six (8%) were inadequate for histological interpretations. The mean number of glomeruli in the biopsy specimens was  $16 \pm 9.9$  (range: 0-47

glomeruli). <http://www.ncbi.nlm.nih.gov/pubmed/23354221>



Diagnostic yield of kidney biopsies performed in a suburban, satellite...

NCBI.NLM.NIH.GOV|BY DRAMAN CR , ET AL.

Abdollah Gamal Dear

د. أحمد يحيى إسماعيل

kindly refer to:

<http://www.uptodate.com/.../indications-for-and...>

This topic last updated: Jan 14, 2016.

If you do not have an access to the site here is the quote :

"Obtaining two cores of renal tissue is generally recommended [ 1,2,14 ]. However, the quantity of tissue required varies with the likely diagnosis. As an example, the distinction of focal (arbitrarily defined as fewer than 50 percent of glomeruli affected on light microscopy) from diffuse proliferative lupus nephritis may require up to 100 glomeruli to make the diagnosis with a reasonable degree of statistical certainty [ 1 ]; obtaining this quantity of renal tissue is rare with percutaneous biopsy and sampling error may therefore explain the seeming variability in clinical outcome in patients with focal disease."

References mentioned here are furnished for free within the site without access.

Thanks



lters

### Indications for and complications of renal biopsy

UPTODATE.COM

Like · Reply · [1](#) · [11 April at 22:25](#) · Edited



[د.أحمد يحيى إسماعيل](#) As u mentioned in the reference ,obtaining this quantity of renal tissue is rare with percutaneous biopsy. I have never seen 100 glomeruli in a biopsy!!!!

Like · Reply · [2](#) · [11 April at 22:38](#)



[Abdollah Gamal](#) Agree 😊:)

## Case 74

**Omer Mala Ahmed**

12 April · Ranya, Iraq



**Omer Mala Ahmed** Dears profs & Doctors  
Howaida Elsayed Mansour, Rageh M. Elsayed, Sherry  
Kamel, Basant Esawy, Aliaa Omar El-hady, Ali Ali Mursi,  
Samarino Helal, Tamer Elfarahaty, ....

**Mona Mansour**

؟

**Aliaa Omar El-hady**

المطلوب ايه من الصورتين دول.. حضرتك مش حاطط عليهم كومننت

**Tamer Elfarahaty** Limitation of left knee flexion



**Rageh Elsayed** ???????

**Omer Mala Ahmed** No i want your suggestions Dear  
Dr Tamer Elfarahaty

**Omer Mala Ahmed** Dr **Aliaa Omar El-hady** please what  
you say in English please? 😊📧

**Omer Mala Ahmed** Any abnormal thing in this post  
please?! 😊📧

**Omer Mala Ahmed** So Sorry I don't knew that the history  
not posted, i wil post it soon few minutes 😊📧 😊📧 😊📧

## Case 75

د. أحمد يحيى إسماعيل

13 April

السلام عليكم ورحمة الله وبركاته.

.A 25 years old female with severe postpartum bleeding examination are & History

.Blood film :normal . <-- PLT revealed to be 7

FDPs+ , INR : normal

ANA +ve , speckled , 1/40

Extractable nuclear antigen antibodies: highly +ve for

.anti-La, -ve dsDNA & anti-Ro

++C3,C4 -- , ESR

Proteinuria couldn't be assessed due to hematuria but no

.edema with normal urine output and s.creat

& IVIG for 2 days & After 3 pulses of solumedrol 1 gm

.repeated PLT transfusion

for & Bone marrow aspirate came out to be diluted

!!repetition

pulse & A hematologist started vincristine

dexamethasone

We , in the immunology unit , diagnosed her as SLE with

resistant thrombocytopenia , so added cyclophosphamide

danazol 200 x 2 with & IV 600 mg , plaquenil 200 x 2

stopping vincristine

wound & We were late in endoxan due to +++CRP

.infection

but we don't know is this the ) <-- PLT ++ to 40

.(effect of vincristine or vincristine

.But 3 days later PLT -- from 140 to 70 to 23

What do you recommendd

## Case 76

### Mohamed Magdy

13 April - Cairo

Girl pt 9 yrs old ,

7 months ago presented by malar rash , oral ulcer ,  
photosensitivity, and alopecia

ANA positive , AntidsDNA highly positive , C3,C4 :  
negative

No proteinuria

CBC show pancytopenia

Pt admitted in paediatric department and diagnosed as  
SLE ,

الحالة اتشخصت بعد شهرين ، أعطوها هيدروكين ، بارامول ، كالسيوم ، فيتامين د  
بعد شهرين الحالة بدأت تشتكي من

Bleeding with stool

عملت منظار وكانت النتيجة

Mild ischemic colitis

وبدأت الكارثة هنا

غريب جدا regimen أعطوها

Pulse solumedrol every week

اخر جرعة واخداها السبت اللي فات ، وللأسف الحالة ساءت أكثر

Cutaneous manifestation still present , bleeding with stool

still present , fungal infection in and around her mouth

CBC الحاجة اللي اتصلت هي

Like



**Ann Atlam** Ola ali  
**Aliaa Omar El-hady**

لا اله الا الله ..... شفاها الله وعافاها

**Howaida Elsayed Mansour** Dear dr **Mohamed Magdy** this poor girl with aggressive lupus , she is likely complicated by lupus mesenteric vasculitis ( LMV) as a part of lupus induced 2ndry systemic small vessels vasculitis causing bleeding per rectum (which will keep her anemic) all these complications are due to poor management ..she is in urgent need to pulse Endoxan 600

mg to be repeated monthly for 6 months each time with 500 mg pulse soluomedrol ....

**Mohamed Magdy** My prof **Howaida Elsayed Mansour** , the bleeding per rectum after pulse steroid ( take 8 times ) ' every week

So , we wait for CT angio

**Howaida Elsayed Mansour** Very strange regimen. ...but believe me this is disease induced (I have patient like her) and not due to pulse steroids bleeding per rectum is well known in lupus mesenteric vasculitis ... but she is urgently needs Endoxan. ..and CT angio may help

**Mohamed Magdy** You prefer Endoxan over mofetil

**Howaida Elsayed Mansour** Sure specially in extra-renal lupus

Cerbritis /vasculitis ...etc Mofetil is a good drug in lupus nephritis. ..

**د.أحمد يحيى إسماعيل** If steroid-induced bleeding , colonoscopy would have shown ulcers rather than signs of ischemia.

**Omer Mala Ahmed** Dear prof **Howaida Elsayed Mansour** thanks for all the above information, you said MMF is a good drug for Lupus Nephritis, but not a good choice for for extra renal lupus, even it is not a good choice for Lupus Pneumonitis ? Great regards

**Howaida Elsayed Mansour** Yes dr.**Omer Mala Ahmed** the best for lupus pnemonitis, cerbritis, vasculitis is pulse Endoxan ...

بدون منافس....!!

**Mohamed Magdy**

my prof **Howaida Elsayed Mansour** اتفق مع حضرتك تماما

**Mohamed Magdy** What the best ttt for bullous lesion in her face , mouth , my prof **Howaida Elsayed Mansour**

**Howaida Elsayed Mansour** The best is induction of remission for the whole disease by pulse Endoxan 600 mg monthly + hydroquine 200 once daily and maintain her on



oral hostacortine 10 - 15 mg daily +Ca/vit D, if the rash is still present add deflocain 50 mg vials IV drip

**Mohamed Magdy** What about dapson ???

**Howaida Elsayed Mansour** I didnt use dapson in lupus rash before but they said it is promising

**Mohamed Magdy**

، بس انا معنديش خبرة في استخدامهمtextفعلا ده اللي موجود في

**Mohamed Hammad** Dapson is of choice in bulbous sle

**Omer Mala Ahmed** Dear Dr **Mohamed Magdy** thanks for sharing this interesting case , as far as there's Pancytopenia & active skin lesions it means the disease is very active & the bleeding most likely is due to the vasculitis or due to thrombocytopenia which causes bleeding every where.

Although it's a difficult decision to give cyclophosphamide for this little girl but iam totally agree with prof **Howaida Elsayed Mansour** that Cyclophosphamide the drug of choice & life saving drug for this critical situation , so we should not think about the future fertility when there's risk on the whole life.

In this case even if there's no vasculitis & rectal bleeding the presence of this resistant Pancytopenia not responding to pulses of steroids despite receiving all the above pulses of steroids given by pediatrician by itself it means candidate for cyclophosphamide pulses.

**Basant Esawy** Thank you dr **Mohamed Magdy** for sharing Poor little girl

As dr **Howaida Elsayed Mansour** mentioned this is critical case of vasculitis either SVV with chch bleeding ulcers or mesenteric vasculitis with ischemia and bleeding ischemic colitis

Cyclophosphamide is the drug of choice in such case 500 to 750 mg / m<sup>2</sup> monthly

Cr angio is mandatory to confirm mesenteric vasculitis Is there any ulcers in the colon , did they take a biopsy?

**Tamer Elfarahaty** Pulse Endoxan for induction of remission in active lupus with 2ry vasculitis ( wait CT angio) plus HCQ . Risk of infertility is lower (13%) in age less than 20 years in comparison to age more than 20 y (50%) . Use pulse up to 6 monthly doses or use euro protocol may decrease risk of ovarian failure in this young girl.

**د. أحمد يحيى إسماعيل** Please consider also secondary antiphospholipid as a cause of ischemia.

**د. أحمد يحيى إسماعيل** Dear profs & Doctors **Omer Mala Ahmed** Howaida Elsayed Mansour , Rageh M. Elsayed, Sherry Kamel , Basant Esawy, Aliaa Omar El-hady, Ali Mursi, Samarino Helal, **Tamer Elfarahaty**,

**Omer Mala Ahmed**

و عليكم السلام و رحمة الله د. د. أحمد يحيى إسماعيل

Thanks for sharing this vague case.

Still we are not sure about the diagnosis of this case , severe postpartum bleeding & positive ANA are not fulfill the ACR criteria for SLE.

The speckled pattern is seen in many conditions and in people who do not have any autoimmune disease.

Titers of 1:80 or lower are less likely to be significant. (ANA titers of less than or equal to 1:40 are considered negative (.

So please give more information about the History & Examination.

It may be DIC case , APL Case.... , what about D.Dimer test ? Fibrinogen level? PT ? Lupus anti coagulant or other Anti phospholipid Antibodies?

**Sherry Kamel** !!!strange case

**Howaida Elsayed Mansour** Dr. أحمد يحيى إسماعيل

The history, the examination and the labs are lacking. ..HB ? WBCs ? ESR ?? C3 , C4 ?? AST, ALT ?? We need numbers not +/- ++....

We need the details of her anti natal course ?? eclampsia /preeclampsia ?? history of previous abortions or DVT ?? What about her PTT ?? Coomb's test ?? she has any bleeding per orifices/echymosis

Is there hepatosplenomegaly or lymphadenopathy or fever ??

anyway this lady should be managed in ICU by internist if the complement is not consumed as it is not clear from your data, then she doesn't have SLE....

DD :

1- HELP syndrome ( Haemolysis , low platelets count and Elevated liver enzymes) this usually complicates toxemia of pregnancy ( eclampsia)

2- Thrombotic thrombocytopenic purpura (TTP)

3- Disseminated intravascular coagulopathy (DIC) All are acute life threatening conditions causing sudden severe drop of platelets count..

Urgent plasmapheresis is highly needed and don't try to give platelets transfer it will lead to more drop of the platelets count

**Basant Esawy**

وعيكم السلام د أحمد يحيى د. أحمد يحيى إسماعيل

This is serious case as mentioned by dr **Howaida Elsayed Mansour**

Either TTP ,DIC, or HELP

Any previous lab for her as simply she may be a case of ITP

Unlikely SLE

Bone marrow is essential

Fibrinogen level , and peripheral bl smear for schistocytes ( fragmented RBCs), bl culture, pro calcitonin , kft, LFT

Agree with plasma pheresis till lab result and diagnosis  
DIC and TTP are serious condition and fatal  
د.أحمد يحيى إسماعيل As I mentioned, no significant data in  
history or examination, no preeclampsia, no  
organomegaly, no abortions.  
CBC shows thrombocytopenia and microcytic anemia due  
to bleeding.

Blood film : normal ( with no blast cells or fragmented  
RBCs)& Coomb's ...[See more](#)

**Howaida Elsayed Mansour**

الارقام مهمة جدا د.أحمد يحيى إسماعيل

د.أحمد يحيى إسماعيل I will give the accurate numbers in shaa  
Allah soon as I recalled the case by memorisation due to  
my travel. She is admitted in our department now.

**Howaida Elsayed Mansour** This is true dear dr.[Basant  
Esawy](#) the patient might simply have ITP with Sjogren  
syndrome (anti Ro and anti La +ve ) by the way HCV  
testing is indicated..

But two things made me think in a more aggressive  
systemic coagulopathy:

- 1- Elevated fibrinogen degradation products (FDP)
- 2- Acute post partum presentation

Plasmapheresis is life saving with pulse soluomedrol but  
please DONT give her platelets transfer this will be fatal -  
even in ITP

## Case 77

### Israt Hasan

22 April

32 years old male, a diagnosed case of refractory AS . During follow up in incidentally diagnosed as HBV infected . HBsAg (+), HBeAg(-), viral load pending, ..we are planning to give etanercept inj. ...do the patient needs any further investigations? Can we give him biologics in this stage? Which one will be more safe ? Should we continue DMARDs also ?

Abdelrahman Amer Tuberculin test ...chest x ray...enbrel can be given if HBV +ve or HCV +ve

Abdelrahman Amer continue SSZ if there is peripheral arthritis

Abdelrahman Amer physiotherapy and active exercise is recommended

Israt Hasan MT - 12 mm induration, x-Ray chest; normal, TB has been excluded..

Israt Hasan Physical therapy- we taught patient NASS protocol.

Israt Hasan There is no peripheral involvement right now.

Israt Hasan We are planning to give Pneumococcal, Meningococcal & Hif vaccine before giving etanercept ! Is there any risk ?

Tamer Elfarahaty U can give these killed vaccines before start etanercept . Also live vaccine at least one month before start biologics

Amal El Ganzoury chest x ray tuberculin test if suspicious start anti tuberculosis ttt for latent TB. After 1 month u can start Anti TNF.

Basant Esawy This one of the tough issues It will be a mutual decision of Rheuma and hepatologist



The hepatitis b anti viral should be started 2 weeks before initiating biologics according to viral load or the hepatologist will inform u when to start if it was very high from the start

Asses the synthetic liver function INR and albumin  
Physiotherapy is essential in this stage , and sport practice as swimming

U can continue NSAIDS and SSZ as if liver function is normal with regular close follow up

There is some studies that continue NSAIDs can give results as biologics

SSZ act peripheral but there is some weak evidence about axial beneficial, but it is also can induce hepatitis as side effect so if you started biologics stop SSZ

**Rageh Elsayed** Yes you can give eneprel after chest x Ray and tuberculin test or better quanteferon is more sensitive if +ve start triple therapy of TB and wait for 1 month then start biologics

**Tamer Elfarahaty** Anti TNF increase risk for TB , HCV& HBV reactivation especially in first months of treatment So ; Screenig for TB & Hepatitis C; B. Is a routine before all biologics .If latent TB : give INH & pyridoxine (B6) for 9 months or combination Therapy for only 6 months to decrease risk of hepatotoxicity and Start anti TNF After one month from TB prophylaxis . Some opnions suggest to start biologics concomitantly with anti TB. For active TB; start biologics after 2 months from anti TB . For resolved hepatitis B ( HBsAg - HBc Ab +) ; give anti TNF and follow patient clinically ,liver functions &viral DNA loading . For chronic inactive ( HBs Ag+): if it is necessary to use biologics; initiate anti vrial 2 to 4 weeks before start anti TNF and continue it during anti TNF treatment .

**Omer Mala Ahmed** Thanks for sharing this case Dr **Israt Hasan**

Yes you can give biological agent, Etanercept is a good choice, iam agree with the dear dr **Basant Esawy** that Antiviral prophylaxis is necessary for your patient

,Irrespective of the HBV DNA titer, pro- phylaxis is initiated with oral antivirals (entecavir 0.5 mg and tenofovir 245 mg, 1 daily tablet), Prophylaxis should be preferably initiated two weeks before the administration of Biological agent or simultaneously .• The treatment period should be until HBsAg becomes negative for patients with chronic B hepatitis(liver disease) , if the patient has no chronic hepatitis Oral antivirals should be continued 6–12 months after biological treatments are completed but In cases in which drugs for B lymphocytes, such as rituximab and atumumab are used the prophylaxis must be continued for 12 months after the completion of treatment.• HBV DNA should be evaluated in 1–6 month intervals (three months on average) .

Great regards

[Howaida Elsayed Mansour](#) Dear dr Israt Hasan ; Anti TNF alpha is contraindicated in HBV infection ...only could be given in HCV infection so ttt his Ankylosing spondylitis by regular NSADS + exercise program and phsiotherapy untill HBV is eradicated1st then we can start anti TNF alpha

[Basant Esawy](#) Dear dr [Howaida Elsayed Mansour](#) etanrcept was approved to be given in HCV in last ACR guidelines for RA 2012  
But this was changed in 2015  
In spite low evidence but it could be used according to viral load and antiviral therapy with collaboration with hepatologist as I mentioned before

same as that of unexposed patients, as long as the patient's viral load is monitored regularly (117,118), conservatively, every 6–12 months. For patients with chronic hepatitis B who are untreated, referral for antiviral therapy is appropriate prior to immunosuppressive therapy (88,119–124). A recent review summarized this evidence (125).

#### Hepatitis C

**PICO E.1.** The recommendation is *conditional* because the evidence is of very low quality, i.e., indirect evidence from patient populations other

**PICOs F.1, F.2, F.3, and F.4.** The recommendation is *conditional* because 1) the evidence is of very low quality, 2) due to potentially lower risk of recurrence of skin cancer with DMARDs versus other therapies based on clinical experience and 2 retrospective studies (104,105), and 3) a lack of data and knowledge about some of the mechanisms of action of biologics and tofacitinib, which may potentially contribute to an increased cancer risk. DMARDs were considered less immunosuppressive than biologics. The Voting Panel also stated that host factors may vary and may influence the risk of

| High-risk condition                                                                | Recommendation                                                                                                                                                                                                               | Level of Evidence (evidence reviewed) |
|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| <b>Congestive heart failure<sup>1</sup></b>                                        |                                                                                                                                                                                                                              |                                       |
| CHF                                                                                | Use combination DMARDs or non-TNF biologic or tofacitinib over TNFi (PICO C.1, C.2 and C.3).                                                                                                                                 | Moderate to Very low (83,84)          |
| CHF worsening on current TNFi therapy                                              | Use combination DMARDs or non-TNF biologic or tofacitinib over another TNFi (PICO C.4, C.5 and C.6).                                                                                                                         | Very low <sup>2</sup>                 |
| <b>Hepatitis B<sup>2</sup></b>                                                     |                                                                                                                                                                                                                              |                                       |
| Active Hepatitis B infection and receiving/received effective antiviral treatment  | Same recommendations as in patients without this condition (PICO D.1).                                                                                                                                                       | Very low (85-92)                      |
| <b>Hepatitis C<sup>2</sup></b>                                                     |                                                                                                                                                                                                                              |                                       |
| Hepatitis C infection and receiving/received effective antiviral treatment         | Same recommendations as in patients without this condition (PICO E.1).                                                                                                                                                       | Very low (92-103)                     |
| Hepatitis C infection and not receiving or requiring effective antiviral treatment | Use DMARDs over TNFi (PICO E.2) <sup>3</sup> .                                                                                                                                                                               | Very low (92-103)                     |
| <b>Past history of treated or untreated malignancy<sup>4</sup></b>                 |                                                                                                                                                                                                                              |                                       |
| Previously treated or untreated skin cancer (non-melanoma or melanoma)             | Use DMARDs over biologics in melanoma (PICO F.1).<br>Use DMARDs over tofacitinib in melanoma (PICO F.2).<br>Use DMARDs over biologics in non-melanoma (PICO F.3).<br>Use DMARDs over tofacitinib in non-melanoma (PICO F.4). | Very low (104-106)                    |
| Previously treated lymphoproliferative disorder                                    | Use rituximab over TNFi (PICO G.1).                                                                                                                                                                                          | Very low (105,107)                    |
| Previously treated lymphoproliferative disorder                                    | Use combination DMARD or abatacept or tocilizumab over TNFi (PICO G.2, G.3 and G.4).                                                                                                                                         | Very low (105,107)                    |
| Previously treated solid organ malignancy                                          | Same recommendations as in patients without this condition (PICO H.1).                                                                                                                                                       | Very low (105,108)                    |
| <b>Previous Serious Infection(s)<sup>5</sup></b>                                   |                                                                                                                                                                                                                              |                                       |
| Previous Serious infection(s)                                                      | Use combination DMARD over TNFi (PICO I.1) <sup>4</sup> .<br>Use abatacept over TNFi (PICO I.2) <sup>5</sup> .                                                                                                               | Very low (109-116)                    |

**Figure 7.** Summary of 2015 American College of Rheumatology recommendations for high-risk patients with established rheumatoid arthritis with moderate or high disease activity and congestive heart failure (CHF), hepatitis B or C, past history of malignancy, or serious infection(s). Green and bolded = strong recommendation. A strong recommendation means that the panel was confident that the desirable effects of following the recommendation outweigh the undesirable effects (or vice versa), so the course of action would apply to most patients, and only a small proportion would not want to follow the recommendation. Yellow and italicized = conditional recommendation. The desirable effects of following the recommendation probably outweigh the undesirable effects, so the course of action would apply to the majority of the patients, but some may not want to follow the recommendation. Because of this, conditional recommendations are preference sensitive and always warrant a shared decision-making approach. A treatment recommendation favoring one medication over another means that the preferred medication would be the recommended first option and the nonpreferred medication may be the second option. Favoring one medication over the other does not imply that the nonfavored medication is contraindicated for use; it is still an option. 1 = conditional recommendations supported by evidence level ranging from moderate level to no evidence, supported by clinical experience and the Food and Drug Administration safety warning with tumor necrosis factor inhibitors (TNFi). 2 = strong recommendations for Hepatitis B were largely based upon the recent American Association for the Study of Liver Diseases practice guidelines (85,86) and clinical experience; conditional recommendations for Hepatitis C were largely supported by very low level evidence based upon case series and clinical experience. 3 = consider using DMARDs other than methotrexate or leflunomide, such as sulfasalazine or

**Howaida Elsayed Mansour** I am speaking about active untreated HBV patient he should receive anti HBV ttt 1st

**Basant Esawy** Yes I am talking about HBV

It is approved now in the new guidelines

Only HCV was approved in the 2012 guidelines

**Basant Esawy** You are right that is what I mentioned earlier at least two weeks and after approval of the hepatologist and according to viral loa

**Basant**

**Esawy** <http://www.rheumatology.org/.../ACR%202015%20RA...>

**Tamer Elfarahaty** Etanercept has short half life relative to other anti TNF with less chance for infection reactivation; But all Anti TNF can be used in HBV with precautions that i mentioned it and according to Last ACR guidelines as dr Basant mentioned.

**Israt Hasan** thanks dear professors ! i'm going to present the case in morning session next monday ! can anyone give me the link of ASAS treatment Guideline 2015 ? and reference link of dose & followup schedule of Chronic HBV infected AS !

## Case 78

**Dalia Hussien Kamel**

23 April

9yrs old female with scoliosis.  
...how is its manegment??











**Aliaa Omar El-hady** Catastrof.. Surgery is paliative for good breathing and reduce neurological complications

**Sherry Kamel** It is severe degree of scoliosis need surgery, as dr. **Aliaa Omar El-hady** mentioned, even to mangle future complications

**Dalia Hussien Kamel** Thanks too much dr **Aliaa Omar El-hady** &dr Sherry kamel..I should refer her to orthopedic or neurosurgeon?...&dr Aliaa u talked about scoliosis in a post before .May u mention me there.plz.I can't reach it ?

**Mona Mansour** Severe cases with cob angle above 45 and Risser score 3 or less should be treated surgically. Refer to spinal orthopaedic surgeon

**Mona Mansour** We have a unit at AL demerdash hospital one of the excellent surgeon is prof Dr abd El mohsein arafa

**Wesam Sleem** Dr **Aliaa Omar El-hady** plz mention me in scoliosis post

**Aliaa Omar El-hady**

**Wesam Sleem** مش عارفة ادخلك الجروب لان حضرتك مش فريند عندي

**Dalia Hussien Kamel**

شرح وافي ومبسط وراااااااع في البوست بارك الله فيكي د علياء

**Aliaa Omar El-hady**

اللهم امين واياكم

## **Case79**

**Abdollah Gamal**

23 April

Dear Colleges and Profs.

This is (MD Exam Commentary Al-Azhar medicine  
Department ....)

This Case is really challenging !

Waiting for your Opinions and Comments



Dept. of Medicine, Faculty of Medicine,  
Al-Azhar University.

**MD Commentary exam, 23<sup>rd</sup> April 2016**

Total time allowed 1.30 hour

A 59-year old man had been previously diagnosed by fault as RA based on history of polyarthritis of the large and small joints, morning stiffness, subcutaneous nodules, and joint deformities in his hands and feet. He was taking methotrexate (10mg/week) and prednisone (5mg/day) which partially controlled his symptoms. He also suffered from systemic arterial hypertension, which got controlled with captopril (100mg/day), propranolol (80mg/day), and hydrochlorothiazide (25mg/day). He noticed recurrent hematuria and over the last few months the patient experienced severe headaches in the occipital region and cervicalgia with irradiation to the left upper limb.

On physical examination, his general condition was good, with a BP level of 130/80 mmHg; he had "swan-neck" deformity of the fingers, "camel back" deformities in his wrists, and fixed deformities in his feet and knees with a significant limitation of movement amplitude both passively and actively. There were several subcutaneous nodules in extension surfaces of his joints, mainly in elbows. There were left brachial paresis graded 4/5, hypertrophy of the left shoulder muscles, and hyperreflexia graded 3/4 in the upper limbs; however, proprioceptive, vibratory, and pain sensitivity were preserved and there were signs of autonomic dysfunction. Cardiovascular and respiratory examinations were unremarkable.

His Lab showed, hypertriglyceridemia, hyperphosphatemia, hyperkalemia, hypocalcemia, lactic acidosis, and creatinine 1.9mg/dL. Rheumatoid factor and anti-CCP antibodies were negative.

Although his radiographs showed extensive bone erosions but with normal density.

- What is the most likely diagnosis ?
- Discuss differential diagnosis and how do you approach such case.
- Outline suggested further investigations required.
- What are the suggested lines of treatment ? and indicate if there is an emergency.

**Good luck**



manifestation of vasculitis. So I think we should investigate the case by measuring acute phase reactant, protein / creat ratio, APL , MRI cervical and cerebral, temporal artery biopsy, hepatitis B And C

**Abdollah Gamal** Dear Colleges and Profs. **Howaida Elsayed Mansour** **Mohamed Abdelkareem**

Thanks for your Comment and information But,  
How can you explain the following :

Hypocalcemia , HyperKalemia, Hypertriglyceridemia,  
Lactic Acidosis, And autonomic Dysfunctions

Thanks

**Howaida Elsayed Mansour** gout may cause different types of renal tubular acidosis...that may explain all these electrolytes disturbances..

gout and gouty tophi may cause autonomic neuropathy /sympathetic chain irritation. ..

**Abdollah Gamal** Thanks Prof. **Howaida Elsayed Mansour** and I would like to add that Renal Deterioration per se might cause that Lab. profile as well .

**Howaida Elsayed Mansour** Yes specially hyperphosphatemia and hypocalcemia ...due to renal impairment. ..

....المهم تكون حلتها صح ف الامتحان

**Abdollah Gamal** Final diagnosis

Chronic tophaceous and mutilans-type gout with spinal involvement

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4276112/>



Gout Initially Mimicking Rheumatoid Arthritis and Later Cervical Spine...

NCBI.NLM.NIH.GOV

**Howaida Elsayed Mansour** I uploaded the case...

dr.Abdollah Gamal

**Abdollah Gamal**

صحيح  
فعلا هي نفسها

**Mohamed Abdelkareem**

بالتوفيق ان شاء الله تعالى

**Abdelmoaty Afifi** tumor lysis syndrome complicated by  
gouty arthritis should be considered. you should search for  
neoplasm

أعجبني . رد . ٥

**Abdollah Gamal** Totally agree !

## Case 80

**Drsamar Aboelneil**

24 April

Dear drs this is 50years old female complaining of edema of knee joint and dark blue lines blow the joint with this investigations what is the management

**Examination:**  
MRI of the right knee.

**Findings:**

- Lax anterior cruciate ligament with sagging of fibers, showing signal alteration as well. Yet, no bony avulsion.
- Normal morphological features of the menisci. No evidence of meniscal tears.
- Medial and lateral femoral condyles small ulcers are seen anteriorly.
- Grade II sprain of the medial collateral ligament is seen with attenuated altered signal fibers.
- Intact posterior cruciate ligament.
- Intact lateral collateral ligament.
- Intact muscular compartments and tendons around the knee joint.
- No evidence of synovial thickening or loose bodies in the joint space.
- Minimal joint effusion is seen.
- Baker's cyst is seen, showing internal septations.
- Intact quadriceps mechanism including the quadriceps tendon, patella, and patellar tendon.

**Conclusion:**

- ❖ Lax ACL.
- ❖ Grade II sprain of MCL.
- ❖ Medial and lateral femoral condyles small ulcers.
- ❖ Minimal joint effusion.
- ❖ Baker's cyst.

Best Regards,  
Dr. Mahmoud Fawzy (MD)

المحاربين الجديدة منزلتان الانشاء والتعمير امام مدرسة الاعدادية الجديدة  
١٤٥١٥٥ ٠٤٧/٣١٤٤٤١٨  
٠١٠٢٣٥٩٤٥٨٠

مركز كفر الشيخ سكان  
الاشعة



اسم المريض / رقم الشيف

متر الوحدة / أ. د. هالة شيبا  
طبيب الوحدة / د. د. عامر حميس  
د. فنان رمضان

المختبر  
al mokhtobar  
مختبر Mokhtobar

رئيس مجلس الإدارة  
أ. د. فؤاد كامل

مدير المعامل  
أ. د. هادي الشربيني

Patient ID : 23416005552  
Patient Name : الأستاذة / منيرة محمد إبراهيم  
Age / Sex : 50 Years / FEMALE  
Referred By : Prof. Dr. الهادي الشربيني  
Client Name : 1533  
Registered : 07-03-2016 13:33  
Collected : 07/03/2016 13:34  
Authenticated : 07/03/2016 19:20  
Reported : 09-03-2016 10:40

### HEMATOLOGY REPORT

TEST NAME RESULT UNIT BIOLOGICAL REFERENCE INTERVALS

#### Complete Blood Picture

|                        |        |               |             |
|------------------------|--------|---------------|-------------|
| Haemoglobin            | L 11.1 | g/dl          | 11.5 - 15.5 |
| Haematocrit (PCV)      | 36.1   | %             | 36 - 45     |
| RBCs Count             | H 5.46 | millions/cmm  | 4.0 - 5.2   |
| MCV                    | L 66.1 | f             | 80 - 100    |
| MCH                    | L 20.3 | pg            | 27 - 33     |
| MCHC                   | L 30.7 | g/dl          | 31 - 37     |
| RDW-CV                 | H 15.6 | %             | 11.5 - 15   |
| Platelet Count         | 237    | thousands/cmm | 150 - 450   |
| Total Leucocytic Count | H 17.3 | thousands/cmm | 4 - 11      |

#### Percent Values

##### Differential Leucocytic Count

|             |      |   |
|-------------|------|---|
| Neutrophils | 76.5 | % |
| Staff       | 4    | % |
| Segmented   | 72.5 | % |
| Lymphocytes | 17.9 | % |
| Monocytes   | 5.4  | % |
| Eosinophils | 0.1  | % |
| Basophils   | 0.1  | % |

#### Absolute Values

|       |                 |            |
|-------|-----------------|------------|
| 13.27 | $\times 10^9/L$ | 2 - 7      |
| 0.69  | $\times 10^9$   |            |
| 12.55 | $\times 10^9$   |            |
| 3.09  | $\times 10^9/L$ | 1 - 4.8    |
| 0.93  | $\times 10^9/L$ | 0.2 - 1    |
| 0.01  | $\times 10^9/L$ | 0.1 - 0.45 |
| 0.01  | $\times 10^9/L$ | 0 - 0.1    |

#### Other Cells

#### Comment :

MILD HYPOCHROMIC MICROCYTIC ANEMIA WITH RBCs ANISOCYTOSIS MODERATE PMN  
LEUCOCYTOSIS RELATIVE LYMPHOPENIA  
TSR, CRP AND HbA1C LOW UP ARE RECOMMENDED SERUM IRON, TIBC, FERRITIN AND  
FOLLOW UP ARE RECOMMENDED

Dr. Hala Shiba  
Professor of clinical pathology  
Faculty of medicine, Cairo university

اسم الفرع / كفر الشيخ  
مدير الوحدة / د. مؤمنة كامل  
طبيب الوحدة / د. مصطفى القريب  
د. احمد الشناوي  
د. مثال المعيد

رئيس مجلس الإدارة  
د. مؤمنة كامل

مدير المعامل  
د. هند الشربيني

Patient ID : 23416005551

Patient Name : الأستاذة / مجيدة محمد ابراهيم

Age / Sex : 50 Years / FEMALE

Referred By : Prof. Dr. الهام ابو عاصي

Client Name : 1853

Registered : 07-03-2016 13:32

Collected : 07/03/2016 13:35

Authenticated : 09/03/2016 16:32

Reported : 12-03-2016 13:23

### IMMUNOLOGY REPORT

TEST NAME

RESULT

PREVIOUS  
RESULT

UNIT

BIOLOGICAL  
REFERENCE INTERVALS

Rheumatoid Arthritis Panel

**Anti Keratin Ab**

Positive 1/10

Negative

By indirect immunofluorescence test

N.B. The starting dilution of Anti-Keratin is 1:10.

اسم الفرع / كفر الشيخ  
مدير الوحدة / د. مؤمنة كامل  
طبيب الوحدة / د. مصطفى القريب  
د. احمد الشناوي  
د. مثال المعيد

رئيس مجلس الإدارة  
د. مؤمنة كامل

مدير المعامل  
د. هند الشربيني

المختبر  
al mokhtobar

Patient ID : 23416005552

Patient Name : الأستاذة / مجيدة محمد ابراهيم

Age / Sex : 50 Years / FEMALE

Referred By : Prof. Dr. الهام ابو عاصي

Client Name : 1533

Registered : 07-03-2016 13:33

Collected : 07/03/2016 13:34

Authenticated : 08/03/2016 13:04

Reported : 09-03-2016 16:40

### IMMUNOLOGY REPORT

TEST NAME

RESULT

PREVIOUS  
RESULT

UNIT

BIOLOGICAL  
REFERENCE INTERVALS

RF Profile

**Rheumatoid Factor (Qualitative)**

Negative

Negative

By slide agglutination test for qualitative detection of Rheumatoid Factor in human serum

اسم الفرع : / عمار الشيخ  
مدير الوحدة : / د. عبد العزيز الشافي

المختبر  
al mokhtabar

رئيس مجلس الإدارة  
أ. د. مومنة كامل

مدير المعامل  
أ. د. هناد الشريوني

Patient ID : 2341600551

Patient Name : الأستاذة / مميصة محمد إبراهيم

Age / Sex : 50 Years / FEMALE

Referred By : Prof. Dr. الهادي أبو غانم

Client Name : 1853

Registered : 07-03-2016 13:32

Collected : 07/03/2016 13:35

Authenticated : 08/03/2016 13:15

Reported : 09-03-2016 10:40

| TEST NAME | RESULT | PREVIOUS RESULT | UNIT | BIOLOGICAL REFERENCE INTERVALS |
|-----------|--------|-----------------|------|--------------------------------|
|-----------|--------|-----------------|------|--------------------------------|

#### RF Profile

|                                                         |     |  |      |          |
|---------------------------------------------------------|-----|--|------|----------|
| Anti Cyclic Citrullinated Peptide (Anti CCP) Antibodies | 7.0 |  | u/ml | up to 17 |
|---------------------------------------------------------|-----|--|------|----------|

Comment : 2

اسم الفرع : / عمار الشيخ  
مدير الوحدة : / د. عبد العزيز الشافي

المختبر  
al mokhtabar

رئيس مجلس الإدارة  
أ. د. مومنة كامل

مدير المعامل  
أ. د. هناد الشريوني

Patient ID : 2341600552

Patient Name : الأستاذة / مميصة محمد إبراهيم

Age / Sex : 50 Years / FEMALE

Referred By : Prof. Dr. الهادي أبو غانم

Client Name : 1533

Registered : 07-03-2016 13:33

Collected : 07/03/2016 13:34

Authenticated : 07/03/2016 19:47

Reported : 09-03-2016 10:40

| TEST NAME | RESULT | PREVIOUS RESULT | UNIT | BIOLOGICAL REFERENCE INTERVALS |
|-----------|--------|-----------------|------|--------------------------------|
|-----------|--------|-----------------|------|--------------------------------|

#### Kidney Function Tests

|                 |      |  |       |           |
|-----------------|------|--|-------|-----------|
| Serum Uric Acid | 4.90 |  | mg/dL | 2.3 - 6.0 |
|-----------------|------|--|-------|-----------|

#### Thyroid Function Tests

|                                   |        |  |        |            |
|-----------------------------------|--------|--|--------|------------|
| TT3                               | L (67) |  | ng/dl  | 70 - 200   |
| TT4                               | 7.4    |  | ug/dl  | 4.5 - 12.5 |
| TSH                               | 2.94   |  | uIU/ml | 0.3 - 5.5  |
| C-Reactive Protein (Quantitative) | 4.90   |  | mg/L   | < 5.0      |



**Examination:**

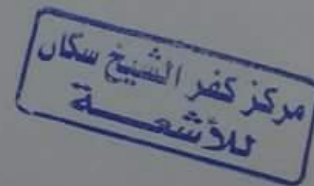
MRI of the right knee.

**Findings:**

- Lax anterior cruciate ligament with sagging of fibers, showing signal alteration as well. Yet, no bony avulsion.
- Normal morphological features of the menisci. No evidence of meniscal tears.
- Medial and lateral femoral condyles small ulcers are seen anteriorly.
- Grade II sprain of the medial collateral ligament is seen with attenuated altered signal fibers.
- Intact posterior cruciate ligament.
- Intact lateral collateral ligament.
- Intact muscular compartments and tendons around the knee joint.
- No evidence of synovial thickening or loose bodies in the joint space.
- Minimal joint effusion is seen.
- Baker's cyst is seen, showing internal septations.
- Intact quadriceps mechanism including the quadriceps tendon, patella, and patellar tendon.

**Conclusion:**

- ❖ Lax ACL.
- ❖ Grade II sprain of MCL.
- ❖ Medial and lateral femoral condyles small ulcers.
- ❖ Minimal joint effusion.
- ❖ Baker's cyst.



Best Regards,

Dr. Mahmoud Fawzy (MD)

١٤٥١٥٥ ٠٤٧/٣١٤٤٤١٨

٠١٠٢٣٥٩٤٥٨٠

المحاربين الجديدة منزلان الانشاء والتعمير امام مدرسة الاعدادية الجديدة

**Howaida Elsayed Mansour** Your case is missing the full history and the simple labs ESR and CRP since we diagnose our cases from the  
1- history and accordingly we orderd the labs and images ...[See more](#)

**Drsamar Aboelneil** Thanks sorry for the missing informations I just started my speciality and I didn't see the patient we talk on internet

**Drsamar Aboelneil** Imaging of knee joint show :

- baker's cyst
- mild effusion
- ulcers at medial and lateral femoral condyls



## Case 81

### Amg Amg

28 April

Dear prof.s & colleagues

Female pt 15ys old e SLE 5ys ago

She has lupus nephritis controlled on cellcept

her last medications are:

Plaquinile

Cellcept

Solupred20

Last labs on 16/4 were normal apart from mild leukopenia

3.8

Today she came with

Fever 40°C

BP 80/50

Vomiting&diarrhea 1day ago

Abdominal pain& tenderness but not rigidity

Labs done today:

ESR>100

CRP +ve 96

AST: 75

Alt 30

Serum amylase: normal

What's your opinion

Lupus hepatitis or bacterial gastroenteritis?????

**Aliaa Omar El-hady** Sherry Kamel- Howaida Elsayed  
Mansour- Mona Mansour- Rageh M. Elsayed-Mohammed  
Hassan- Omer Mala Ahmed- Basant Esawy

**Sara Saeed F**

**Basant Esawy** You have critical ill patient

Rule out infection as you patient is well covered by immunosuppressive

Liver disease with Sle is 3 types

1- associated lupoid hepatitis ( autoimmune hepatitis) and it is rapidly responding to steroids and MMF plus associated with high AST and alt

2- drug induced and the drugs you mentioned is not associated except in sporadic case reports

3- lupus hepatitis which is rare and due to small vs vasculitis plus it will be associated with active disease and it is limited to case report studies

My opinion your pt has sepsis and infection rather than active disease and may proceed to septic shock as her pl pr is low , CRP is high

Leukopenia and thrombocytopenia could be associated with septicemia and DIC

For bl culture, stool culture , occult bl in stool , pro calcitonin , FDP, INR , the labs which may indicate activity are c3,c4, prt creatinine ratio and Coombs test

After culture samples withdrawal start empirical antibiotics

If occult bl in stool do colonoscopy and biopsy if infection ruled out and colonic vasculitis suspected

**Amg Amg** Many thanks dear prof.dr Basant Esawy

After all that her mother refuse admission😞 in our dep.

And i try to arrange with internal medicine dep. in the general hospital in her city

**Mona Mansour** Give her symptomatic treatment for vomiting, fever and give fluids and investigate by first pelviabd sonar for peritonitis . Consult gastroentrologist or int medicine: for IBD, mixed CT with scletoderma,

vasculitis. These disease , autoimmune hepatitis .can occur rarely in SLE

**Mohammed Hassan** Good evening all dear profs

I agree with dr **Basant Esawy**

CRP is +very in lupus in infection,serositis,arthritis. Here mostly caused by septicemia

So critical hospitalization, do inv and antibiotic

**Rageh Elsayed** Yes totally agree with my colleagues regarding infection in SLE patient is bad omen must be treated aggressive way and must be hospitalized for work up of infection and disease activity don't wait culture start liberal antibiotic until you complete your investigations

**Howaida Elsayed Mansour** Dear all, dear dr.Amg Amg ...your SLE patient is in lupus flare with gut involvement likely lupus mesenteric vasculitis (LMV) the elevated liver enzymes is just an association with lupus flare as lupus hepatitis is a painless condition ....LMV causes severe abdominal pains and signs **of** peritonitis with guarding with or without 2ndry bacterial infection ( bacterial infection is only a part of the story not the whole story and usually 2ndry to disease activity ...)

; Please do urgent abdominal CT with contrast and dont wait for the results this is an emergancy ...start anti coagulation with clexan 60 mg sc daily + Tavanic 500 mg vials IV once /24 hour + 1 gm pulse soluomedrol , prempran vial IM to control vomiting keep an eye on serum K and correct any deficiency due to vomiting, fluid replacement as she is shocked ...we may shift to Endoxan if there is no responce and reassessment of her condition ..acc to the responce to therapy ..good luck

**Amg Amg** Many thanks dear prof dr **Howaida Elsayed Mansour**

We gave her antibiotics

Antiemetic

Antipyretic

Maintain her on 20mg steroids until we prove which of which activity or sepsis

But Unfortunately her mother refuse admission totally despite discussing dangerous outcome of the case

**Howaida Elsayed Mansour** Dont wait to prove this is infection/ activity as this is very difficult and usually both may coexist ....she needs pulse soluomedrol and shift to Endoxan. ..

**Amg Amg**

تمام يا افندم بس المشكلة فين المريضة  
رفضوا يتحجزوا خالص وحاولت حتى فيها تروح المستشفى العام اللي في بلدها  
واتواصل مع الدكاترة هناك برفضوا رفضت  
انا عرضت الحالة هنا للتعلم والاستفادة وطبعاً لو العيان جت هاتبغ الخطوات اللي  
حضرتك وصيتي بها

## Case 82

د. أحمد يحيى إسماعيل

9 May 2016

A 30 y. old female with SLE & antiphospholipid syndrome with recurrent abortions.

She is on prednisolone for 6 months, starting with 30 mg tapered till she is on 10 mg now. She is also on Ca+ vit. D. She is planning to get pregnant.

What is your opinion regarding her DEXA and your recommendation regarding prevention of fragility fracture especially if she got pregnant.

Thanks in advance.



# Royal Scan

Phone: ( ) - - - - - Fax: ( ) - - - - -

DXA Bone Densitometry Report: ٢٠١٦

for Dr/AHMED YEHYA.

our patient RANYA RASHAD ABD ELLATEIF completed a BMD test on 23/04/2016 using the Lunar DPX DXA System analysis version: 13.20) manufactured by GE Healthcare. The following summarizes the results of our evaluation

## PATIENT BIOGRAPHICAL:

|              |                            |             |            |             |          |
|--------------|----------------------------|-------------|------------|-------------|----------|
| Name:        | RANYA RASHAD ABD ELLATEIF. |             |            |             |          |
| Patient ID:  | (not specified)            | Birth Date: | 01/09/1985 | Height:     | 155.0 cm |
| Gender:      | Female                     | Exam Date:  | 23/04/2016 | Weight:     | 68.0 kg  |
| Indications: |                            | Fractures:  |            | Treatments: |          |

## ASSESSMENT:

The BMD measured at AP Spine L1-L4 is 1.036 g/cm<sup>2</sup> with a T-score of 1.3-. This patient is considered osteopenic according to World Health Organization (WHO) criteria. Bone density is between 10 and 25% below young normal. Fracture risk is moderate. Treatment is advised.

The BMD measured at Femur Neck is 0.856 g/cm<sup>2</sup> with a T-score of 1.3-. This patient is considered osteopenic according to World Health Organization (WHO) criteria. Bone density is between 10 and 25% below young normal. Fracture risk is moderate. Treatment is advised.

The BMD measured at Femur Total is 0.847 g/cm<sup>2</sup> with a T-score of 1.3-. This patient is considered osteopenic according to World Health Organization (WHO) criteria. Bone density is between 10 and 25% below young normal. Fracture risk is moderate. Treatment is advised.

The BMD measured at Forearm Radius 33% is 0.847 g/cm<sup>2</sup> with a T-score of 0.5-. Bone density is up to 10% below young normal. This patient is considered normal according to World Health Organization (WHO) criteria. Fracture risk is low.

| Site         | Region     | Measured Date | Measured Age | WHO Classification | Young Adult T-score | BMD                     |
|--------------|------------|---------------|--------------|--------------------|---------------------|-------------------------|
| AP Spine     | L1-L4      | 23/04/2016    | 30.6         | Osteopenia         | 1.3-                | 1.036 g/cm <sup>2</sup> |
| Left Femur   | Neck       | 23/04/2016    | 30.6         | Osteopenia         | 1.3-                | 0.856 g/cm <sup>2</sup> |
| Left Femur   | Total      | 23/04/2016    | 30.6         | Osteopenia         | 1.3-                | 0.847 g/cm <sup>2</sup> |
| Left Forearm | Radius 33% | 23/04/2016    | 30.6         | Normal             | 0.5-                | 0.847 g/cm <sup>2</sup> |

World Health Organization (WHO) criteria for post-menopausal, Caucasian Women:

Normal: T-score at or above -1.50

Osteopenia: T-score between -1 and -2.50

Osteoporosis: T-score at or below -2.50

## RECOMMENDATIONS:

NOF Guidelines recommend treatment for patients with a T-score of -1.5 and below with risk factors or -2.0 and below without risk factors. Effective therapies are available in the form of bisphosphonates (Fosamax and Actonel), and Evista. Hormone therapy may be an option based on review of risks and benefits of treatment. All patients should ensure an adequate intake of dietary calcium (1200 mg/d) and vitamin D (400-800 IU daily).

All patients should ensure an adequate intake of dietary calcium (1200 mg/d) and vitamin D (400-800 IU daily).

## FOLLOW-UP:

People with diagnosed cases of osteoporosis or at high risk for fracture should have regular bone mineral density tests. For patients eligible for Medicare, routine testing is allowed once every 2 years. The testing frequency can be increased to one year for patients who have rapidly progressing disease, those who are receiving or discontinuing medical therapy to restore bone mass, or have additional risk factors.

Based on these results, a follow-up exam is recommended in ٢٠١٨

Sincerely,  
(not specified)

Exam Date: 23/04/2016

Page 1 of 1

Patient: RANYA RASHAD ABD ELLATEIF

د. أحمد يحيى إسماعيل Dear profs & Doctors Howaida Elsayed  
Mansour Mona MansourOmer Mala Ahmed Tamer

Elfarahaty Abdollah Gamal Basant Esawy Aliaa Omar El-hady

**Howaida Elsayed Mansour** She just having osteopenia that need only increase the dose of one alfa and daily oral calcium + diet the most important is to keep her on daily clexan 40 mg sc throughout the coming pregnancy course...

**د.أحمد يحيى إسماعيل** But guidelines recommend bisphosphonates for whom takes  $\geq 7.5$  mg prednisone daily for  $> 3$  months.

**Mona Mansour** You said she is planning to get pregnant, so it is enough to have Calcium and vitamin D. The action of bisphosphonate is slow so you will get no advantage if you stop treatment after few months.

**Basant Esawy** You are right according to ACR guidelines premenopausal females on steroids  $> 7.5$  more than 3 m you should give bisphosphonate

But as dr **Howaida Elsayed Mansour** and dr **Mona Mansour** said , ca and vit d is enough especially if she is planning to get pregnant

So in near future you can taper steroids to de 5 mg and ca , vit d will help as there is controversy about bisphosphonate cumulative effect in premenopausal women

**Tamer Elfarahaty** 1) ACR guidelines for premenopausal with childbearing potential on predinsoline more than 7.5 mg/day more than 3 months; recommended bisphosphonates only for those with prevalent fragility fracture . 2) Risk of bisphoshonate to the featus from previous exposure ( short duration before conception ) is not well defined ; so it is better to stopped 6 months before pregnancy . Actonel (with short half life ) may be safest as it is rapidly cleared from blood after it stopped with less fetal toxicity. 3) Asses serum 25 OH vit D as vit D def. corelate with lower BMD and target vit D level in SLE: 40

ng / ml. 4) Although HCQ may inhibit conversion of 25 OH vit D to 1, 25 OH vit D but some studies suggest HCQ as a protective agent against bone loss in SLE treated with glucocorticoids. 5) ACR recommended serial DXA ;annual serum vit D level & assessment of incident fragility fracture (with low evidence) .

د.أحمد يحيى إسماعيل

جزاكم الله خيرا على الرد المفصل الرائع.

**Tamer Elfarahaty**

جزانا وإياكم .

د.أحمد يحيى إسماعيل What about one-alpha in pregnancy?

**Tamer Elfarahaty** Why one alpha ? Its use is limited due short half life ;rapid onset of action; inability to increase vit D stores and higher risk of hypercalcemia . Vit D3 is recommended as prophylactic or therapeutic use in vit D deficiency even in pregnancy .

### Case 83

**Heba Nagieb**

24 February 2016

السلام عليكم  
بعد اذنكم جاتلى حاله 2.6 forearm-osteoporosis و hip and spine  
normal  
و عاملة since 15 year hystrectomy  
تاخذ aclastaa و لا لا

**Ali Mursi** You may measure but D and calcium 1st if  
normal give aclasta if creatinine clearance above 35

**Samarino Helal** f

## **Case 84**

**Amaly ElJana**

29 February 2016

A 6 years female patient suffers from neck pain for 3 months. there was spasm in neck muscles. she takes NSAIDs; local muscle relaxant but with no improvement. now she starts to suffer from pain in right upper arm. please your help for diagnosis and management





**محمد عبد الفتاح** Why the position of neck in kyphosis

**Amaly ElJana** It is due to loss of cervical lordosis

**Aliaa Omar El-hady** What is her complete cervical examination and neurological examination

**Amaly ElJana** Pain with range of motion ,local tenderness on rt side .i saw her three month ago her neurological examination was normal

**Amaly ElJana** Her mother said that no history of trauma

## Case 85

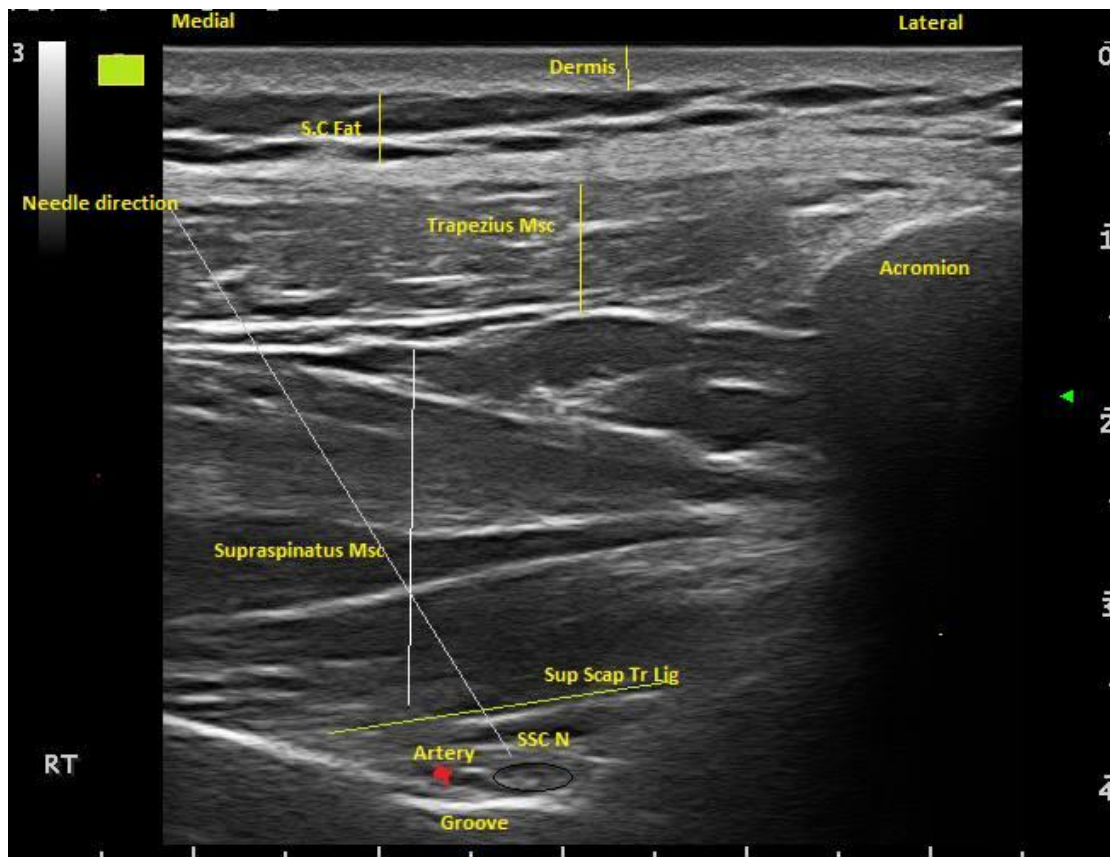
**Kareem Omar**

16 May 2016

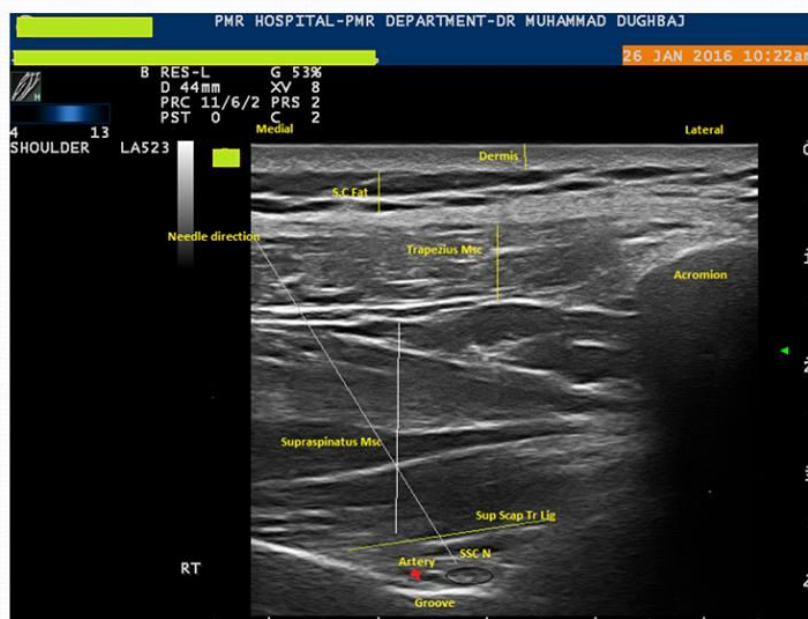
صباح الخير زملائي الأعزاء  
سؤال بخصوص حالة مريضة

50 yrs old female c/o Rt shoulder pain and limitation in ROM. After examination and investigation she was diagnosed as having Rt shoulder Rotator cuff tendinitis. This was more than 2 months back. Today she came for physiotherapy for the same previous condition BUT..BUT..BUT she gave a history of surgical intervention for cancer ovary followed by chemotherapy and radiotherapy as well. The last radiotherapy session was one week ago and she completed her postoperative treatment. X-ray shoulder was done to recheck for any changes or masses and it was clear ... my question is : when to start physical therapy sessions (exercise and pain relief electrotherapy) for this lady after the last radiation session?

**Muhammad Dughbaj** Good morning Dr **Kareem Omar**  
1st exclude 2ndries ..bone scan  
TENS & IF can be started immediately  
Gentle Codman ex no resistance  
Exclude associated bursitis ..GHJ arthritis by diagnostic US & relevant lab  
best is SSC N BLOCK..suprascapular nerve block using ALM..anatomical land mark ...better US guidance  
Therapeutic US ,Microwave and short wave and ESWT..extra corporeal shock wave therapy are absolutely contraindicated  
**Muhammad Dughbaj** <https://m.facebook.com/groups/1540849006235003?view=permalink&id=1563750463944857>



## TECHNIQUE OF ULTRASOUND GUIDED SUPRASCAPULAR NERVE BLOCK



DR MUHAMMAD DUGHBAJ 2016



## TECHNIQUE OF ULTRASOUND GUIDED SUPRASCAPULAR NERVE BLOCK

The suprascapular nerve is seen as rounded hypoechoic structure with honeycomb appearance beside the pulsating suprascapular artery confirmed by power Doppler underneath the transverse scapular ligament.

A 22 G 2.5 inches needle is inserted in plane with longitudinal axis of the US beam through a medial to lateral approach .

The needle shaft is visualized along its course and the needle tip is seen in proximity of the nerve, a mixture of 10 ml bupivacaine 0.5% and triamcinilone 40 mg is injected under real time ultrasound seeing the spread of the injectant.

DR MUHAMMAD DUGHBAJ 2016

## TECHNIQUE OF ULTRASOUND GUIDED SUPRASCAPULAR NERVE BLOCK



A linear array multi frequency transducer 4-13 MHZ Esaote Italy is placed in transverse orientation over scapular spine.

Moving the transducer cephalic, the trapezius muscle, the supraspinatus muscle and the bony fossa are visualized.

The transducer is moved laterally keeping the same orientation parallel to scapular spine to identify the suprascapular notch.



DR MUHAMMAD DUGHBAJ 2016

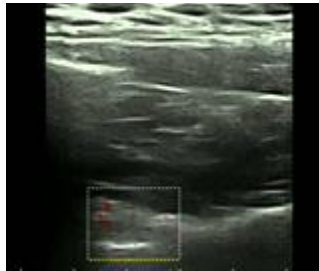


**Muhammad Dughbaj** added 4 photos to February 14, 2016 in KUWAIT PMR NMSK US DR MUHAMMAD DUGHBAJ.

14 February 2016 ·

## ULTRASOUND GUIDED SUPRASCAPULAR NERVE BLOCK

**ghbaj** <https://youtu.be/0FK2nRb4JXs>



US G SSC N BLOCK

## ULTRASOUND GUIDED SUPRASCAPULAR NERVE BLOCK

YOUTUBE.COM

**Kareem Omar** Thanks Dr.mohamed

**Omer Mala Ahmed** Dear prof Dr **Muhammad**

**Dughbaj** thanks for your informative comment , can SSC nerve block be done blindly without US ? This injection is done to relief pain & to allow manipulation of shoulder freely ? Great regards

**Muhammad Dughbaj** To compare a CT guided versus an anatomical landmark approach in a randomised, single blind trial examining the efficacy of suprascapular nerve block for shoulder pain in patients with degenerative joint/rotator cuff disease

**Muhammad**

**Dughbaj** <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1755124/>



Suprascapular nerve block in chronic shoulder pain: are the radiologists better?

NCBI.NLM.NIH.GOV

**Muhammad**

**Dughbaj** <http://www.nerveblocks.net/.../suprascapular-nerve-block>



Nerveblock - Peripheral Regional Anaesthesia

NERVEBLOCKS.NET

**Muhammad Dughbaj** <http://www.scielo.br/scielo.php...>

Suprascapular nerve block: important procedure in clinical practice

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SCIELO.BR

**Omer Mala Ahmed** Thanks allot dear My lovely prof **Muhammad Dughbaj** for these golden informations 👍

☐ GREAT REGARDS

**Muhammad Dughbaj** Welcome dear brother Dr **Omer Mala Ahmed**

july

## **CASE 86**

**Mohammed Hassan**

3 July 2016

Female patient aged 18 ys old presented to me with 2 months polyarthritis (wrists, MCPs, PIPs, knees, ankles) , Fever high spiky, pain was severe that made her wheelchair, No rashes, no photosensitive, no oral or genital ulcers, no eye c/o, no lymphadenopathy, no chest or GIT c/o no GUI, no other sources of infection found

Inv:

RF, ANA, anti CCP all -ve

CBC: anemia, high leucocytosis 18000(neutrophils), thrombocytosis

Ferretine: very high

Urine analysis: free

ASOT:-ve

Salmonella typhi and paratyphi -ve

High ESR over 100 1st hr

CRP 60

I suspected adult onset Still's disease for DD of hematological disorder

Gave her 60 Prednisone, MTX, CA and vit D

After 2 weeks she called me and said that arthritis marked improved and fever became better but not resolved yet

But her lab shows persisted abnormality (leucocytosis 22000 !!! and thrombocytosis and high CRP 56 !!!!! and ESR 1st hr become 85 !!!

I'll see her tomorrow

PLZ for your opinion for persistent lab parameters and D.D

Thanks

AlertsPrevious VisitsWrite usContact us

Patient Report No-32

Find...1 of 2100%

اسم الفرع / ميت غمر  
مدير الوحدة / ا.د. نليدة جواهر

**معامل البرج**  
Al Borg Laboratories

مدير المعامل  
علاء عبد الرحيم

Patient ID : 46116010295

Patient Name : الأستاذة / منى محمد الحاجر

Age / Sex : 20 Years / FEMALE

Referred By : Prof.Dr. محمد حسن

Client Name : 6307

Registered : 7/2/2016 15

Collected : 02/07/2016 15

Authenticated : 03/07/2016 01

Reported : 7/3/2016 19

| TEST NAME                         | RESULT  | UNIT | BIOLOGICAL<br>REFERENCE |
|-----------------------------------|---------|------|-------------------------|
| C-Reactive Protein (Quantitative) | H 56.18 | mg/L | < 5.0                   |

اسم الفرع / ميت عمر  
مدير الوحدة / د. مها صالح  
طبيب الوحدة / د. اينس عزازي

# معامل البرج

Al Borg Laboratories

Patient ID : 46116010295

Patient Name : الأستاذة / منى محمد الحجر

Age / Sex : 20 Years / FEMALE

Referred By : Prof. Dr. محمد حسن

Client Name : 6307

Registered : 7/2/20

Collected : 02/10

Authenticated : 03/10

Reported : 7/3/20

## HEMATOLOGY REPORT

### TEST NAME

### RESULT

### UNIT

### BIOLOGICAL REFERENCE

### Complete Blood Picture

|                        |        |               |           |
|------------------------|--------|---------------|-----------|
| Haemoglobin            | 12.1   | g/dl          | 11.5 - 15 |
| Haematocrit (PCV)      | 39.9   | %             | 36 - 45   |
| RBCs Count             | 4.50   | millions/cmm  | 4.0 - 5.2 |
| MCV                    | 88.7   | fL            | 80 - 100  |
| MCH                    | 27.0   | pg            | 27 - 33   |
| MCHC                   | 31.0   | g/dl          | 31 - 37   |
| RDW-CV                 | 15.0   | %             | 11.5 - 15 |
| Platelet Count         | H 500  | thousands/cmm | 150 - 450 |
| Total Leucocytic Count | H 22.0 | thousands/cmm | 4 - 11    |

### Percent Values

### Absolute Values

### Differential Leucocytic Count

|             |      |   |       |                 |           |
|-------------|------|---|-------|-----------------|-----------|
| Neutrophils | 83.2 | % | 18.30 | $\times 10^9/L$ | 2 - 7     |
| Staff       | 4    | % | 0.88  | $\times 10^9$   |           |
| Segmented   | 79   | % | 17.42 | $\times 10^9$   |           |
| Lymphocytes | 10.2 | % | 2.24  | $\times 10^9/L$ | 1 - 4     |
| Monocytes   | 6.5  | % | 1.43  | $\times 10^9/L$ | 0.2 - 1   |
| Eosinophils | 0.0  | % | 0.00  | $\times 10^9/L$ | 0.1 - 0.5 |
| Basophils   | 0.1  | % | 0.02  | $\times 10^9/L$ | 0 - 0.2   |

### Other Cells

### Comment :

MARKED PMN LEUCOCYTOSIS WITH ABSOLUTE MONOCYTOSIS  
MILD THROMBOCYTOSIS



د. هويدا اسماعيل  
مستشارة المختبر الطبية بكلية طب طنطا  
مكتورة في التحريات الطبية  
مستشارة الميكروبيولوجيا الطبية والصناعية

Patient ID : 2016123626

Register

Patient Name: الأستاذ / منى محمد الحجار

Print Date

Referred by : د. / مستشفى جامعة طنطا

Age/Sex

## VIROLOGY REPORT

| <u>Test Name</u>      | <u>Result</u>  | <u>Unit</u> |
|-----------------------|----------------|-------------|
| <b>Ferritin Level</b> |                |             |
| Serum Ferritin        | More than 1500 | ng/ml       |

Patient ID : 2016123626

Patient Name: الأستاذ / منى محمد العجر

Referred by : مستشفى جامعة طنطا / أ.د

Reg

Prim

Age/

### Complete blood picture

| Test Name                     | Result | Unit          |
|-------------------------------|--------|---------------|
| Haemoglobin                   | 9.7    | L gm/dl       |
| Haematocrit (PCV)             | 30.1   | L %           |
| RBCs Count                    | 3.70   | L mil/cmm     |
| MCV                           | 81.4   | fL            |
| MCH                           | 27.0   | pg            |
| MCHC                          | 32.2   | %             |
| RDW-CV                        | 13.0   | %             |
| Platelet count                | 362    | Thousand/cm   |
| Total Leucocytic Count        | 18.7   | H Thousand/cm |
| Differential Leucocytic Count |        |               |

|             | Relative Value | Absolute Result                  |
|-------------|----------------|----------------------------------|
| Neutrophils | 78 %           | $14.59 \times 10^3 / \text{cmm}$ |
| Staff       | 6 %            | $01.12 \times 10^3 / \text{cmm}$ |
| Segmented   | 72 %           | $13.46 \times 10^3 / \text{cmm}$ |
| Lymphocytes | 18 %           | $03.37 \times 10^3 / \text{cmm}$ |
| Monocytes   | 3 %            | $00.56 \times 10^3 / \text{cmm}$ |
| Eosinophils | 1 %            | $00.19 \times 10^3 / \text{cmm}$ |
| Basophils   | 0 %            | $00.00 \times 10^3 / \text{cmm}$ |
| Other cells |                |                                  |

#### Comments

The RBCs show Mild Normocytic Normochromic anaemia for age & sex. Reticulocytes recommended.

The WBCs show Mild Leucocytosis with absolute Neutrophilia. ESR, CRP are recommended.

**Mohammed Hassan** Dear prof s Dr  
Omer Mala Ahmed, Mona Mansour, Rageh  
Elsayed, Tamer Elfarahaty, Basant Esawy, Howaida  
Elsayed Mansour, ...

**Nehal Hamdy** Dr Mohammed Hassan  
first I agree with diagnosis . it is a case of adult onset still's  
disease  
regarding her lab ...[See more](#)

**Mohammed Hassan** Thank you Dr Nehal for your  
informative comment

..

**Omer Mala Ahmed** My dear Dr Mohammed  
Hassan thanks for sharing this interesting case  
Really to me in every case of suspected Stills disease  
which not present with typical clinical features we should  
exclude hematological malignancies.  
In your case i see the RBC mass also low in one CBC  
which is significant( it may be due to infiltration of bone  
marrow by WBC blast cells) , never depend on Spiky fever  
or very high S.Ferritin & absence of blast cells in periphery  
because they all can occur in hematological malignancies  
, believe me i previously saw two cases of spiky fever  
,arthritis & very high S.Ferritin & the bone marrow biopsy  
revealed leukemia !

So the top DD in your case is leukemia, please before  
starting long term steroid & DMARD arrange for BM  
biopsy, if negative for hematological malignancies then  
you can surely proceed your management as Adult onset  
Stills disease.

**Mohammed Hassan** Thank you very much dear Dr Omer  
Mala Ahmed for your informative comment  
Yes, I will require BM biopsy for her to exclude  
hematological disorder s

**Omer Mala Ahmed** you are welcome, please update us  
about the results

**Mona Mansour** Dear dr. **Mohammed Hassan** I agree with you all as regards high possibility of AOS, however we should be cautious as Adult onset Still's is a diagnosis of exclusion. Clinically if there is synovitis it goes more with Still's that leukemia as there is pain with much less synovitis in leukemia, also lactate dehydrogenase could be high in favor of leukemia, scintigraphy could help. Of course biopsy is the diagnostic investigation. Also exclude hepatitis and ask for and sonar. if by exclusion diagnosed Still's you can increase methotrexate to 20 mg/ was for 3 months and see the response and taper the corticosteroids gradually

**Mohammed Hassan** Thank you very much dear Dr **Mona Mansour** for your informative comment

**Rageh Elsayed** Thanks dr **Mohammed Hassan** for your nice case I am with you AOSD 1- if we have leucocytosis and normal platelets and lymphocytes this will be infection 2- if you have leucocytosis and decreased platelets and lymphocytes think about leukemia and the type will be according to blast cell%.

3-high dose of CS may cause this elevation of leucocytosis above 20000 and also activity

4- plz do blood ,urine and sputum analysis to rule out infection

5- LDH is recommended if malignancy is suspected Plus pan ct or PET

6- BM biopsy can be done if you exclude activity and infection good luck

**Mohammed Hassan** Thank you dear Dr **Rageh Elsayed** for your informative comment

**Tamer Elfarahaty** Thanks dr **Mohammed Hassan** 1) Spiky Fever ;polyarthritis ; high ferritin ; leukocytosis & thrombocytosis increase possibility of AOSD . Check LDH ; AST ; ALT & serum UA .Serum Ferritin (H type) is more specific for AOSD. 2) Yes u need to exclude hematological Mg ( in both adult &systemic JIA) by BM

biopsy before start high oral dose or pulse steroid . Blast cell may not appear early. Abdominal US ;panCT & PET may be helpful 3) Also rule out viral infection (hepatitis & PCR for EBV ). 4)steroid may be behind persistent leukocytosis so increase dose of DMARDs for tapering steroid and see the result.

**Mohammed Hassan** Thank you dear Dr [Tamer Elfarahaty](#) for your informative comment

**Bassel El-Zorkany** Please note - irrespective of AOSD features - that patients on steroids have leucocytosis (due to decreased leucocyte apoptosis). Further, the best option in treating your case is tocilizumab if affordable.

**Mohammed Hassan** Thank you very much dear respectable prof Dr [Bassel El-Zorkany](#)  
It's my honor that you give me your kind advice dear great prof

**Basant Esawy** Totally agree with you dr Mohammed Hassan for management , as my respected colleagues mentioned AOSD is the first diagnosis  
Malignancy should be ruled out (BM biopsy)and infection ( blood culture )

Leucocytosis is steroid induced reaction

Taper steroid gradually and follow

LFT and BM biopsy if MAS suspected and fever is persistent but it is more common with pediatrics



## **Case 87**

**Nooran Nooran**

27 July 2016

8years old boy complaining of bilateral symmetrical arthritis of wrist and knee joint for more than 1y duration . associated with fever (38 - 39)not more with no special character . no skin rash

No GIT manifestation .

No chest manifestation.

No enthesitis .

No personal or family history of psoriasis .

No neurological manifestation .

No history of recurrent tonsillitis

pt only on NSAID and long acting penicillin .

By examination :

pt is feverish 38,5 .

sub lingual ,sub mandibular LN enlargement no other LN enlargement.

Bilateral wrist effusion .no tenderness . normal ROM .no knee arthritis .no other joint affected.

muscle power 5 .

no skin lesion ,no nail abnormality .

Investigation

ESR :117

CBC : HB 8 , WBC normal , platelets normal reticulocyte 2%.

liver enzyme normal

RF negative

ANA negative

serum ferritin normal.

glycosylated ferritin pending

plan x-ray hand pending.

PLZ for your opinion about diagnosis and management .

**Omer Mala Ahmed** Dear Dr **Nooran** thanks for sharing this case

The duration of arthritis & fever are About one year duration?

What about blood film ?

Type of Anemia?

Coombs test ?

GUE ?

GSE for any evidence of bleeding?

Abdominal US ?

Although I know you putted the sJIA is at the top of DDx in this case but still it has no fulfill criteria for sJIA & need further work .

Local lymphadenopathy is of no great significance to be related with sJIA because in sJIA the lymphadenopathy is generalized as it's a systemic disease

In this case we should put the following DDx in mind :

1-Hematological malignancies ( Do blood film +/- BM examination) that also lead to auto immune hemolytic anemia & high Retic count .

2- eJIA with inflammatory bowel disease that lead to chronic blood loss & High Retic count.

3- sJIA : after doing the above recommended investigations

4-oJIA in association with other related diseases causing this severe anemia & very high ESR

**Nooran Nooran** Thanks dr.**Omer Mala Ahmed**.

**Nooran Nooran** its my first time to see pt today . and he already diagnosed as sJIA by another doctor but pt not received therapy . and i need glycosylated ferritin in trying to exclude sJIA , before starting more invasive investigation (BM examination in by history no evidence of bleeding . I will do what U recommend me

## Case88

### **Mohammed Hassan**

28 July 2016

Yesterday, I see a Female patient aged 18 years complaining of polyarticular JIA since she was 8 ys old with aggressive course she was on MTX, NSAIDs, (at age of 11 ys he developed melena d.t NSAIDS)

She said that receives solumedrol pulse therapy with temporary improvement. She becomes diabetic d.t Prolonged GC

She said that received enbrel for 5 ys without improvement. And actemra for 6 months with temporary improvement for only first 3 months

Now she is active , hand deformed, bilateral knee and ankle destructed, limited et hip rotation , stunted growth No fever, skin rash, photosensitiveity,oral ulcers, eye, GIT, chest manifestations

Her lab:

High ESR and CRP

CBC normal

RF -ve

Anti CCP -ve

TSH normal

Low serum vit D

Serum amyloid A normal

Liver and kidney functions normal

24 prturia 2.5 GM !!!!!!!!!!!

I asked for repeat 24 h prturia, ANA, anti dsDNA, ESR ,CRP

In this poor case:

1. What is the the best way of management?
2. What about high protein in urine?

Dear prof Drs [Bassel El-Zorkany](#) Howaida Elsayed Mansour [Omer Mala Ahmed Sherry Kamel Rageh Elsayed Tamer Elfarahaty Mona MansourBasant Esawy](#) Amira Shahin

**Aliaa Omar El-hady** Howaida Elsayed Mansour Mona  
Mohsen Dalia Fayez Amira Shahin Hanan Saleh

**Sherry Kamel** Dear dr. this high protein in urine may be is manifestation of membranous nephropathy ...the best line of treatment to try cellcept ....regarding the patient joint deformity ...is there erosion or is it non erosive arthritis??? Because it is very strange to be found this aggressive deforming resistant arthritis with negative Anti\_ccp and RF

**Sherry Kamel** Also , it is important to be sure that the anti \_ TNF be given with full dose and regular , I am usually when see patients like urs , with full history taking I found that patient didn't take the biologic regular or didn't receive the full dose

**Omer Mala Ahmed** Dear de **Mohammed** thanks for sharing this interesting case.

This poor patient with distractive arthritis to me is an aggressive JIA , as you know that the Arthritis associated with SLE is unlikely to be destructive.

The long term systemic inflammation ( uncontrolled disease) is behind her Protein urea .as you know that the diagnosis of Amyloidosis is confirmed with biopsy,It is important to recognize that not all biopsy sites offer the same sensitivity. The best sites from which to obtain a biopsy specimen in systemic amyloidosis are the abdominal fat pad ( Fat pad Aspiration) and rectal mucosa (approaching 90% sensitivity for fat pad and 73-84% for rectal mucosa), so biopsy of the organ with the most severe clinical involvement is often unnecessary.

To me in this case Abatacept is recommended for polyarticular disease , Abatacept is adviced when a TNF inhibitor does not control disease after 4 months of therapy ,It also is indicated after a second TNF inhibitor is trialed and the patient continues to have moderate to high disease activity.

You can continue MTX with Abatacept in addition to 10 mg prednisone & Ca +Vit D

**Sherry Kamel** Great , valuable comments& recommendations , 😊👍

**Omer Mala Ahmed** Dear Dr **Sherry Kamel** Thanks for your nice appreciation , you are Great 😊👍😊👍

**Hanan Saleh** Dear all

Thanks for sharing this challenging case

What about her serum albumin& cholesterol levels because 2.5 gms proteinuria in 24 hours is very close to 3 gms of nephrotic syndrome which together with hypoalbuminemia& high cholesterol level& oedema( nephrotic syndrome) make the patient more susceptible to DVT & thrombotic events& should then have anticoagulant therapy

Renal biopsy will give a clue whether there is IgA nephropathy or membranous nephropathy

This patient seems to have adrenal insufficiency, she became steroid dependent d. t. Prolonged use of high doses of steroids ( she is stressed)

To make an accurate assessment we first have to check her serum K & Na levels

In case she has hyperkalemia& hyponatremia she can then receive solumedrol in saline & not in glucose

You may also ask for

Albumin/ creat. Ratio

C3& C4

حنان السباعي

**Basant Esawy** Thank you for sharing dr **Mohammed Hassan**

Really challenging

You should rule out MCTD or overlap syndrome as rhupus

Ana, DNA and uRNP , c3, c4

Kidney biopsy is essential

Rtx not proved in pediatric

But there is rising studies about beneficial effect



of abatacept in SLE and it is effective in JIA, I have a case of lupus and working well with her

Hope to be fine

**Howaida Elsayed Mansour** Hi all dear dr Mohammed Hassan where are the photos 😊😊

Nevertheless this poor girl with aggressive JIA and started to have amyloidosis, you are right we should rule out lupus...to me pulse Endoxan 600 mg monthly for 6-8 months + physiotherapy lots of vit D ....(this is my experience not evidence based) but we have a study running on now at Ain Shams University concerning this treatment option with great and promising results..of course..+ hydroxychloroquine and prednisolone 10 mg daily...keep up updated

### Case89

**Dalia Hussien Kamel**

29 July 2016

Plz dear drs,30yrs old female pt have swelling opposite lower tibia of 1yr duration,hard in consistency,of lemon size,painless but recently she has pain,...Is this ganglion or has another dd?&for surgical removal????





**Howaida Elsayed Mansour** For MRI and full labs DD benign tumours

**Hanem Salama** Ultrasound can be helpful? It may be lipoma?

**Howaida Elsayed Mansour** Yes of course; yesterday I saw a case exactly the same like your case.. and the swelling was at the same place....!! sent her for musculoskeletal US...

**Dalia Hussien Kamel** X-ray free??prof **Howaida Elsayed Mansour**

Like · Reply · 1 · 29 July 2016 at 21:31

**Howaida Elsayed Mansour** Yes thats why MRI is needed

**Mohammed Hassan** I think MSUS or MRI is mandatory for diagnosis

## Case90

**Aliaa Omar El-hady** shared Hamdy Ibrahim's [post](#).

31 July 2016

· copied

.....

Case story (From the work experience)

One day in our ICU Embaba Fever Hospital I was consulted by two of my dear colleagues for a critical case in one of the hospital wards admitted 2 days earlier from the emergency department as jaundice for investigations , he was a 44 years old man , working in a caffee, shisha smoker known diabetic , but not known to be hypertensive , The story started 8 days before admission when he was exposed to motor vehicle accident (Tok-Tok) while he was working , after that he started to suffer pain and swelling in his left knee joint , for which he received NSAIDS from a private dispensary , the patient didn't improve ,he became febrile ,felt nauseated off and on and had lost his appetite , his urine became darker, and the relatives noticed that his eyes became icteric , the general condition deteriorated , brought to the ED and admitted as jaundice for investigations . There was no history of recent operation, tooth extraction or previous transfusion and no history of chronic illness ,rheumatologic disease , or history suggestive of autoimmune disorder , he was not drug abuser . He has normal sexual practice , no urogenital symptoms or any dermatologic abnormalities . There was no history of recent exposure to a child with rash .and the family history was not contributory .

On physical examination : The patient was confused , pale and toxic , jaundiced but not cyanosed , the patient was lying flat with no congested neck veins . there was pitting edema of both lower limbs Temp. 38.9 C , pulse110/m RR: 23/m B.P : 80/50 mmHg , neck lax with no signs of meningeal irritation

First degree bed sore on the lower back , normal genital

examination , There was no lymphadenopathy , and skin examination was normal .

Chest :Bilateral basal crackles, Heart : normal S1,S2 with no additional sounds or murmurs

Abdomen: soft with no organomegaly Joint examination : both wrists, elbows and knee joints were red tender with soft tissue swelling (the swelling is more on the left knee with clinical evidence of effusion)

Investigations : C.B.C : WBCs: 13.6,00 RBCs count 3.15 million Hgb: 9 , HCT: 26.2 MCV :83.2 , MCH28.6, MCHC :34.4 , Plt.120,000 Ly : 11.2 , Mo.3.5 Gr.: 85 RBS :

250mg/dl creat.2,8 mg/dl ,urea:102 ESR: 70 1 st hour

,urinalysis : pus cells over 100, albumin + , sugar +

serum electrolytes were within normal range , S. bilirubin .5 mg/dl , SGOT : 137, SGPT : 33 mg/dl , alkaline

phosphatase : 106 Serum albumin : 3mg/dl , PT: 12 sec.,

Widal malta tests were negative , ABG: PH:7.28 PaCo2:

30 Po2: 76 HCO3:20.2 , Hepatitis markers :were negative

, ANA , RF : negative . HIV test was negative . Chest x-ray

: small bilateral heterogenous opacities occupying the lower lung zones , clear both costophrenic angles ,

Abdominal ultrasound : bright liver . (Q) What other

important investigations should be done?

-Aspirated fluid specimen from the left knee joint revealed growth of gram positive cocci (staphylococcus aureus) ,

Blood culture : growth of staphylococcus aureus

(Q) What is the differential diagnosis?

(1) Septic arthritis with multi organ dysfunction (2)

Reactive arthritis (3) Viral : (a) Parvo virus B19 (b)

Hepatitis A (c) Hepatitis B (d) Hepatitis C (E) HIV 1,2

(4) Rheumatoid arthritis (5) Systemic lupus erythematosus

(6) Infection and other multisystem diseases particularly brucellosis, tuberculosis , leptospirosis and infective endocarditis .

Discussion of the differential diagnosis ?

Septic arthritis with multi organ dysfunction is the most likely diagnosis based on the rapidly progressive joint



swelling ,associated with evident criteria of sepsis : fever ,leukocytosis , tachycardia , tachypnea ,Pa Co2 <32 torr (30 torr), stah. Aureus is the most common cause of septic arthritis , the arthritis may result from trauma ,blood culture are positive in 50% of cases, routine joint x-ray may be normal for up to 14 days after the onset of symptoms , the ESR is elevated MRI is more sensitive than other techniques , septic arthritis is typically monoarticular but 15-20 %of cases are polyarticular, plain x-ray examination of the left knee was normal with no bony erosion , osteolytic lesion and no soft tissue swelling . MRI of the left knee joint revealed : Anterior condylar ligament contusion , torn posterior horn of medial meniscus and anterior horn of the lateral meniscus , lower femoral area of abnormal signal ? inflammatory in nature ? post traumatic , mild knee joint effusion with small Baker cyst formation , The multiorgan dysfunction together with the sepsis present(Severe sepsis) was evident in the form of : altered mental status (confusion) , hypotension , metabolic acidosis , decreased urine output (on follow up), hyperbilirubinemia ,hypoalbuminemia and coagulopathy (low platelets )

Gonococcal arthritis excluded by negative culture for gonococci and absence of uro genital symptoms and dermatitis .

-In the absence of gastrointestinal or urethral symptoms reactive arthritis was unlikely . Rheumatoid arthritis is basically a clinical diagnosis ,insidious onset rather than abrupt onset , pleural effusion is the commonest pulmonary manifestation of rheumatoid arthritis and negative gram stain on joint aspiration. No history of exposure to a child with rash excludes excludes rheumatoid arthritis like polyarthritis in adults which occur after infection with parvo virus B19. – Infection and other multi system diseases must be considered , chronic infection particularly brucellosis , tuberculosis and infective endocarditis were considered in the differential diagnosis .

Brucellosis is characterized by attacks of evening fever associated with shaking chills and profuse sweating and arthralgia rather than arthritis and if arthritis is to occur it is usually monoarticular affecting large joints (vertebral column ,hip or knees) with leucopenia rather than leukocytosis is characteristic . Tuberculosis has an insidious onset , skeletal TB most frequently involves the spine or weight bearing joints , Articular cartilage destruction indicated by narrowing of the joint space which was not present in this case .

Infective endocarditis was a possibility but no cardiac murmur or signs to support such a diagnosis .- Viral causes of arthritis was excluded by negative hepatitis markers , hepatitis B patients can develop transient polyarthritis involving wrists , knees ,ankles, and small joints of the hands typically accompanied by a rash , the arthritis usually subsides at the onset of jaundice . In hepatitis C viral infection (HCV) inflammatory oligoarthritis or polyarthritis occurs in 2-5 % of patients with chronic HCV infection .chronic hepatitis C infection is associated with abnormal immune function including cryoglobulinemia and positive rheumatoid factor ( causing diagnosis confusion with rheumatoid arthritis) . Acute HIV associated arthritis tend to be self limiting lasting less than 6 weeks usually presents as oligoarticular or polyarticular , however HIV test was negative . The anicteric form of leptospirosis may present with arthritis ,pneumonitis , orchitis ,cholecystitis , myocarditis ,meningitis and uveitis ,jaundiced patients have severe and rapidly progressive form of the disease with liver failure and acute kidney injury .

However ,there was no suggestive occupational exposure or contact with animal or contaminated water and there was no abdominal symptoms , muscle ache , or rash .

The patient received antibiotics initially empirical after joint aspiration , then according to the result of culture and sensitivity tests for both blood and joint aspirate .antibiotics

and fluid support given initially together with the analgesics and antipyretics . The patient markedly improved , fever and the joint swelling subsided ,the general condition improved and he sent to orthopedic specialist for repair of his torn ligaments .

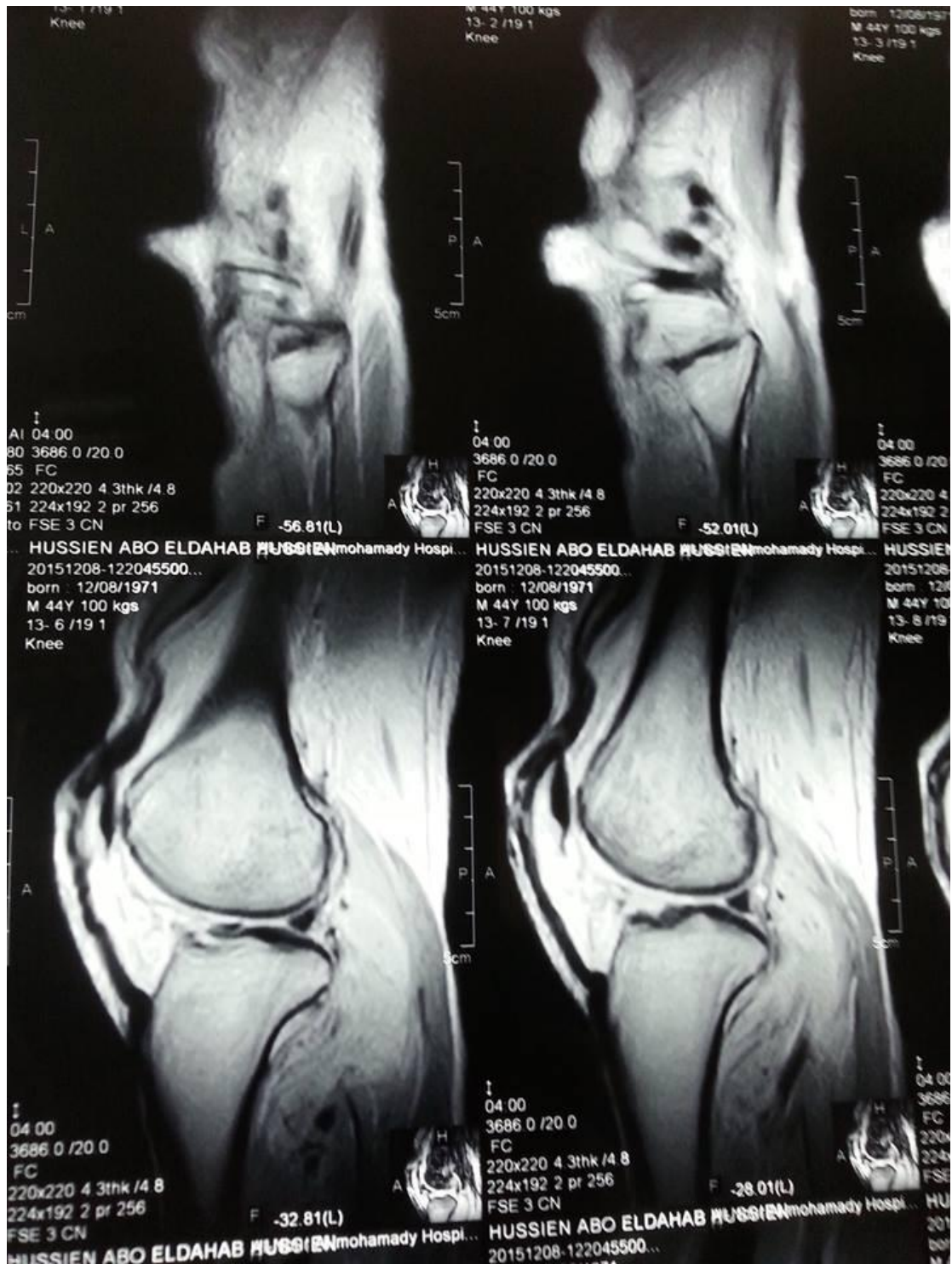
Diagnosis: Septic arthritis with multi organ dysfunction

<https://m.facebook.com/story.php...>









03:57  
300.0 / 16.2  
220x194 4.3thk / 4.8  
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HUSSEIN ABO ELDAHAB HUSSEIN mohamady Hospi...  
20151208-122045500...  
born 12/08/1971  
M 44Y 100 kgs  
12- 6 /19 DS  
Knee

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HUSSEIN A  
20151208-122  
born 12/08/1  
M 44Y 100 kg  
12- 7 /19 DS  
Knee

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20151208-122045500...  
born 12/08/1971  
M 44Y 100 kgs

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300.0 / 16.2  
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256x174r 4.512  
SE

HUSSEIN AB  
20151208-1220  
born 12/08/19



## Case91

**Hamdy Ibrahim**

28 January 2016

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Case story (From the work experience)

One day in our ICU Embaba Fever Hospital I was consulted by two of my dear colleagues for a critical case in one of the hospital wards admitted 2 days earlier from the emergency department as jaundice for investigations , he was a 44 years old man , working in a caffee, shisha smoker known diabetic , but not known to be hypertensive , The story started 8 days before admission when he was exposed to motor vehicle accident (Tok-Tok) while he was working , after that he started to suffer pain and swelling in his left knee joint , for which he received NSAIDS from a private dispensary , the patient didn't improve ,he became febrile ,felt nauseated off and on and had lost his appetite , his urine became darker, and the relatives noticed that his eyes became icteric , the general condition deteriorated , brought to the ED and admitted as jaundice for investigations . There was no history of recent operation, tooth extraction or previous transfusion and no history of chronic illness ,rheumatologic disease , or history suggestive of autoimmune disorder , he was not drug abuser . He has normal sexual practice , no urogenital symptoms or any dermatologic abnormalities . There was no history of recent exposure to a child with rash .and the family history was not contributory .

On physical examination : The patient was confused , pale and toxic , jaundiced but not cyanosed , the patient was lying flat with no congested neck veins . there was pitting edema of both lower limbs Temp. 38.9 C , pulse110/m RR: 23/m B.P : 80/50 mmHg , neck lax with no signs of meningeal irritation

First degree bed sore on the lower back , normal genital examination , There was no lymphadenopathy , and skin



examination was normal .

Chest :Bilateral basal crackles, Heart : normal S1,S2 with no additional sounds or murmurs

Abdomen: soft with no organomegaly Joint examination : both wrists, elbows and knee joints were red tender with soft tissue swelling (the swelling is more on the left knee with clinical evidence of effusion)

Investigations : C.B.C : WBCs: 13.6,00 RBCs count 3.15 million Hgb: 9 , HCT: 26.2 MCV :83.2 , MCH28.6, MCHC :34.4 , Plt.120,000 Ly : 11.2 , Mo.3.5 Gr.: 85 RBS : 250mg/dl creat.2,8 mg/dl ,urea:102 ESR: 70 1 st hour ,urinalysis : pus cells over 100, albumin + , sugar + serum electrolytes were within normal range , S. bilirubin 5 mg/dl , SGOT : 137, SGPT : 33 mg/dl , alkaline phosphatase : 106 Serum albumin : 3mg/dl , PT: 12 sec., Widal malta tests were negative , ABG: PH:7.28 PaCo2: 30 Po2: 76 HCO3:20.2 , Hepatitis markers :were negative , ANA , RF : negative . HIV test was negative . Chest x-ray : small bilateral heterogenous opacities occupying the lower lung zones , clear both costophrenic angles , Abdominal ultrasound : bright liver . (Q) What other important investigations should be done?

-Aspirated fluid specimen from the left knee joint revealed growth of gram positive cocci (staphylococcus aureus) , Blood culture : growth of staphylococcus aureus

(Q) What is the differential diagnosis?

(1) Septic arthritis with multi organ dysfunction (2) Reactive arthritis (3) Viral : (a) Parvo virus B19 (b) Hepatitis A (c) Hepatitis B (d) Hepatitis C (E) HIV 1,2 (4) Rheumatoid arthritis (5) Systemic lupus erythematosus (6) Infection and other multisystem diseases particularly brucellosis, tuberculosis , leptospirosis and infective endocarditis .

Discussion of the differential diagnosis ?

Septic arthritis with multi organ dysfunction is the most likely diagnosis based on the rapidly progressive joint swelling ,associated with evident criteria of sepsis : fever



,leukocytosis , tachycardia , tachypnea ,Pa Co<sub>2</sub> <32 torr (30 torr), stah. Aureus is the most common cause of septic arthritis , the arthritis may result from trauma ,blood culture are positive in 50% of cases, routine joint x-ray may be normal for up to 14 days after the onset of symptoms , the ESR is elevated MRI is more sensitive than other techniques , septic arthritis is typically monoarticular but 15-20 %of cases are polyarticular, plain x-ray examination of the left knee was normal with no bony erosion , osteolytic lesion and no soft tissue swelling . MRI of the left knee joint revealed : Anterior condylar ligament contusion , torn posterior horn of medial meniscus and anterior horn of the lateral meniscus , lower femoral area of abnormal signal ? inflammatory in nature ? post traumatic , mild knee joint effusion with small Baker cyst formation , The multiorgan dysfunction together with the sepsis present(Severe sepsis) was evident in the form of : altered mental status (confusion) , hypotension , metabolic acidosis , decreased urine output (on follow up), hyperbilirubinemia ,hypoalbumenemia and coagulopathy (low platlets )

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associated with shaking chills and profuse sweating and arthralgia rather than arthritis and if arthritis is to occur it is usually monoarticular affecting large joints (vertebral column ,hip or knees) with leucopenia rather than leukocytosis is characteristic . Tuberculosis has an insidious onset , skeletal TB most frequently involves the spine or weight bearing joints , Articular cartilage destruction indicated by narrowing of the joint space which was not present in this case .

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The patient received antibiotics initially empirical after joint aspiration , then according to the result of culture and sensitivity tests for both blood and joint aspirate .inotropics and fluid support given initially together with the

analgesics and antipyretics . The patient markedly improved , fever and the joint swelling subsided ,the general condition improved and he sent to orthopedic specialist for repair of his torn ligaments .

Diagnosis: Septic arthritis with multi organ dysfunction

**Hanem Salama**

هل ممكن يحصل septic arthritis without leucocytosis?

**Aliaa Omar El-hady** WBCs 13.6

**Sherry Kamel** It is very interesting case 👍👍

Like · Reply · 2 · 31 July 2016 at 16:19

**Eiman Abd El Raoof** That is mean septic arthritis is the cause of multisystem affection?

**Youssy Said** Heterogeneous lung opacities???

## Case 92

**Mohammad Moinuddin** shared [MSKUS & Intervention training.](#)'s post.

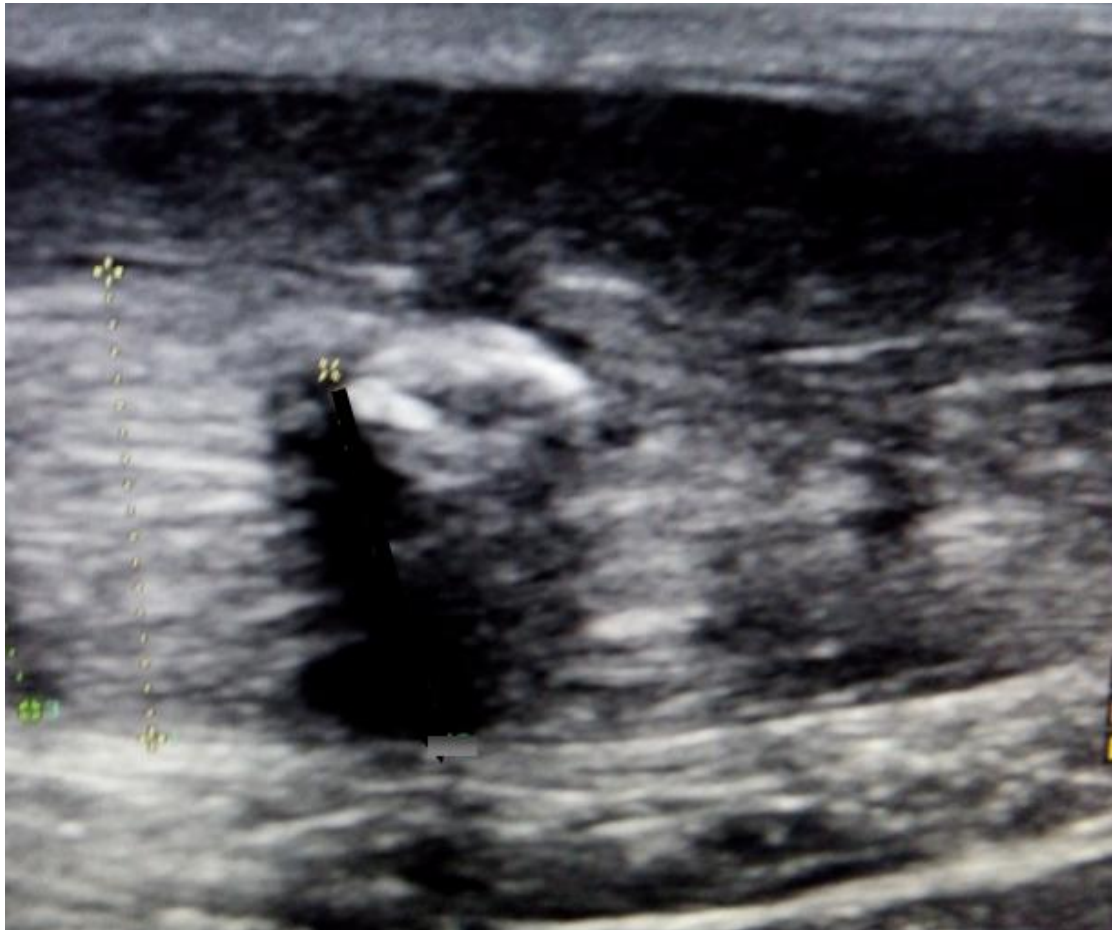
5 August 2016

**ACHILLES TENDINITIS AND CALCIFICATION:**  
Ultrasound image.









**MSKUS & Intervention training.** added 3 new photos. Like Page  
5 August 2016

**ACHILLES TENDINITIS AND CALCIFICATION:**  
Ultrasound image. The patient (a policeman), 45 yrs came to me with chronic heel pain and painful limping. Six months back he had a history of jumping and he consulted an Orthopedic Specialist. Though pain relieved initially he gradually developed chronic pain and came to me.

**Amal El Ganzoury** hi dr Omer  
shock wave therapy is quite beneficial in tendo achills calcification.

but should exclude secondary causes of calcification gout  
enthesitis due to sero -ve spondyloarthropathy etc. ..

**Mohammad Moinuddin** I am dr. Moin. Thanks for your  
comments. You are right. But in this case trauma was the  
cause. No S/S suggestive of SpA or gout was found.

### Case93

**Israt Hasan**

23 August 2016

A 23 yr old male present wth gradual swelling over medical side of thigh just above knee , swelling is firm non tender mild raise of temperature ..history of vigorous exercise for reducing body wt (pt was 96 kg before exercise ).now wt is arround 70kg .no difficulty in ADL . ROM full no h/o trauma .what is the diagnosis ?



**Sherry Kamel** please do MRI or diagnostic MSUS.....may be hemmatoma,posttrauma then was clacified

**Mohammed Hassan** What about stress tests of the knee!  
Is the swelling mobile or tender or produce pain with any movement as pelvic rotation?

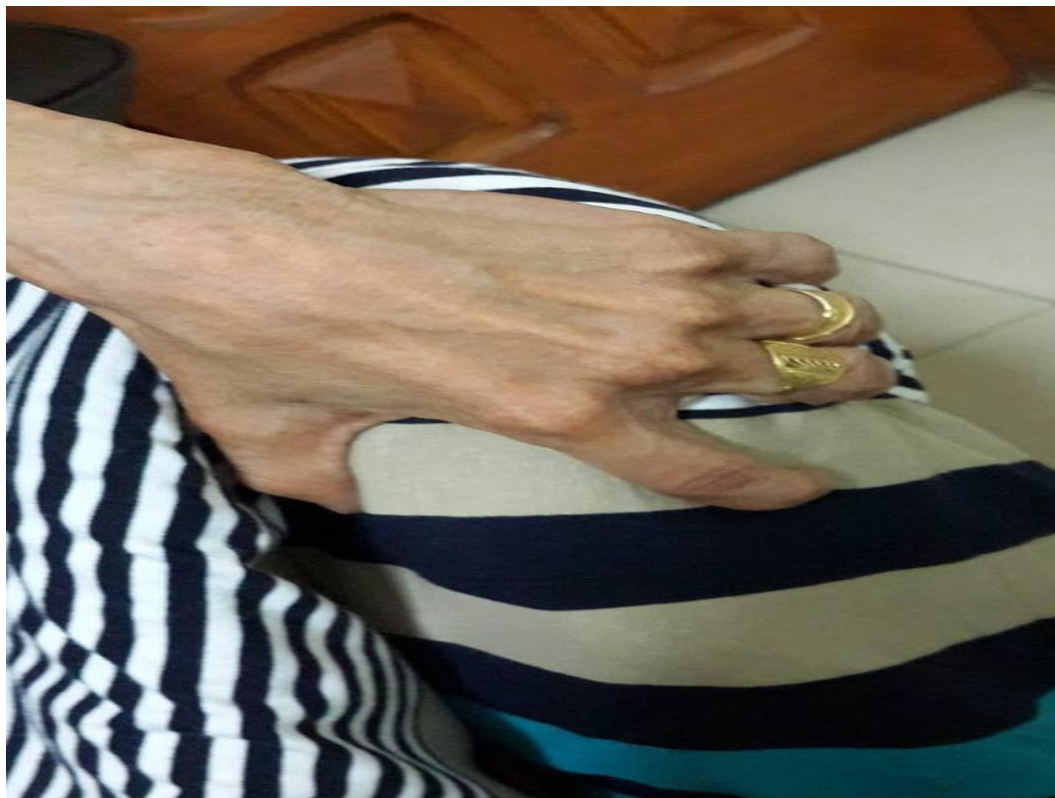
Best is MSUS and if non conclusive do MRI as Dr **Sherry Kamel** said

## Case94

### **Howaida Elsayed Mansour**

5 September 2016

She is just 30 years old, but fulfilling the criteria and the stigmata of "Werner's syndrome (adult onset progeria) an autosomal recessive CT disease : criteria  
fixed elbow scare ... (may be at the maleoli)  
Skin and subcutaneous fats atrohy sp at the limbs  
Senil skin hyperpigmentations (allover the skin)  
Scleroderma like face (bird like)  
White eye lashes and eye brows but not the scalp hair...!  
(Ask the pt)  
Bilateral cataract in young female  
Early menopause....  
Causes of death: CVD events and cancer











**Omer Mala Ahmed** Very interesting & very rare case dear Prof **Howaida Elsayed Mansour**.

What about your treatment lines in this case to at least decrease the progression of the disease or associated complications ? Is it true that Vit-C supplementation is help in reversing the premature aging in such cases ? Is there any evidence of alopecia on the scalp or face or just graying of hair?

**Howaida Elsayed Mansour** Yes dr **Omer Mala Ahmed** genetic counseling and high doses of vit C , vit D, Calcium and folic acids are the main stay of ttt this lady was having excessive loss of scalp hair ( senile hair) with arthralgias and scleroderma like face ( bird face) thats way was diagnosed once as lupus and others diagnosed her as scleroderma. ...!! but the key here is No raynauds phenomenon. ...and no scleroderma without raynauds. ..

**Omer Mala Ahmed**



**Howaida Elsayed**

**Mansour**<http://www.ncbi.nlm.nih.gov/pubmed/24690071>

this was my 1st case of werners syndrome puplished in  
international journal of rheumatic diseases in 2014

## Case95

### Amg Amg

8 November 2016

Dear profs.&colleagues:

Peace be upon you

Aya, 12ys old female pt,

at age of 6 she started to develop skin rash all over the body, accompanied by itching and complicated by abscesses formation.

That rash mainly affect scalp-complicated by hair falling-area under the breasts and around the umbilicus.

That attack is recurrent annually by the same manner.

Every time she sought medical advice and diagnosed and treated as fungal infection with little improvement.

Some physicians prescribed diprofos with little improvement also.

6 weeks ago she developed the attack and admitted to hospital.

Blood culture was positive for pseudomonas.

ESR: 90

Hb:11.3

WBC:7.7

Plt:265

ANA, Anti dsDNA, ANCA, AntiRO, AntiRNP:all are -ve

Pelvi-abdominal US: NAD

S.ferritin:10

There is

No articular symptoms

No fever

No lymphadenopathy

No oral ulcers

No Raynaud's ph.

Ig G:2182.8

Ig E:331.7

What's your diagnosis& management?







**Cairo University**  
Specialized pediatric hospital  
Clinical Pathology Department

مستشفيات جامعة القاهرة  
مستشفى الأطفال الجامعي التخصصي الجديد (النياباتي)  
قسم الباثولوجيا الإكلينيكية

جامعة القاهرة

|             |               |              |            |
|-------------|---------------|--------------|------------|
| Name        | ايه سيد حسن   | Patient No   | 0860748    |
| Lab No      | 32098         | Sex          | Female     |
| Age         | 12 Y          | Request Date | 23/10/2016 |
| Referred By | مناعة - وقائي |              |            |
| Location    |               |              |            |

**IMMUNOLOGY**

| Test       | Result | Unit  | Reference Range    |
|------------|--------|-------|--------------------|
| IgM        | 198.6  | mg/dl | ( 52.0 - 242.0 )   |
| Serum IgA  | 298.5  | mg/dL | ( 70.0 - 312.0 )   |
| <u>IgG</u> | 2182.8 | mg/dL | ( 639.0 - 1349.0 ) |
| Serum IgE  | 331.7  | IU/mL | ( 1.9 - 170.0 )    |

Asma' El-Boushy

**Nermeen Ahmed Foud** what about dermatological consultation?

**Amg Amg** Dear dr **Nermeen Ahmed Foud**

Dermatological consultation diagnose and treat the case as fungal infection

**Nermeen Ahmed Foud** diagnosed in our hospital?

**Amg Amg** Yes

But last attack admitted to 6 October university hospital who requested blood c&s

**Amg Amg** What about Ig G&E high levels

Is this a case of cutaneous vasculitis??????

Like · Reply · 1 · 8 November 2016 at 22:39

**Nermeen Ahmed Foud** I don't think so..waiting for our seniors

**Marwa Maher**

م

**Ann Atlam** Skin biopsy can be helpful in this case

**Wesam Mostafa**

د. عزة ممكن تعملي ليهم منشن

**Amg Amg**

aryبصي يا وسام بالنسبة للحالة دي د.زينب عثمان قالتلي دوري في ١  
immunodeficiency syndromes

لسة بقول بسم الله لقيتهم ٣٠٠ حالة نادرة !!!!!!!!!!!!!!!

**Amg Amg**

قصداك اعمل منشن للاستاذة

**Wesam Mostafa**

اه

**Wesam Mostafa**

هههههه

**Rehab Salem** Is their nail affection??family history of psoriasis??

**Amg Amg** No

## Case96

د. أحمد يحيى إسماعيل

4 November 2016

A 13 year old boy with lupus thrombocytopenia resistant to initial

treatment with pulse solumedrol 1 gm for 3 days followed by full dose steroid , azathioprine and HCQ?

Now plt count is zero.

No active bleeding.

WBC count is 5

U/S : mild splenomegaly.

C4 slightly consumed.

Now no other clinical parameters of activity.

Blood film is normal.

What do u recommend, my dear professors

Like

**Sherry Kamel** Dear dr. This serious situation, pt need platelet daily to increase platelet level to more than 20,000

**Sherry Kamel** You can add eltrombopag 50mg daily for 2week then re-evaluate Plat count

| I - Eltrombopag                                                                                                                               |        |          |                  |     |
|-----------------------------------------------------------------------------------------------------------------------------------------------|--------|----------|------------------|-----|
| used in chronic refractory idiopathic thrombocytopenic purpura and treatment of thrombocytopenia in people with chronic hepatitis C infection |        |          |                  |     |
| Revolade                                                                                                                                      | 14 tab | 1,600.00 | Eltrombopag 25mg | GSK |
| "                                                                                                                                             | 14 tab | 3200.00  | Eltrombopag 50mg | GSK |

**Aliaa Omar El-hady** Howaida Elsayed Mansour  
**Sherry Kamel** Alternative line of treatment IVIG or rituximab

**Abdelrahman**

**Amer** <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4753950/>



Thrombocytopenia in Systemic Lupus Erythematosus:  
Clinical Manifestations,...

NCBI.NLM.NIH.GOV

**د. أحمد يحيى إسماعيل** What about immunosuppression? I thought of starting endoxan but hematological consultation recommended vincristine! What is your opinion?

**Sherry Kamel** We usually try Endoxan with steroid pulse, if no response add IVIG to increase Plt rapidly then maintaining pt on eltrombag 50mg for 2week

**Sherry Kamel** Lastly., we have resistant case like urs and we will try rituximab , regarding vincristine, we don't have experience about it, although it was suggested in our case by prof. Ali yousef

**Omer Mala Ahmed** Dear dr **د. أحمد يحيى إسماعيل** thanks for sharing this interesting case .

- First we should know that your poor patients with resistant thrombocytopenia has a poor prognosis.
- for such severe thrombocytopenia we need an urgent intervention with using a rapidly acting drugs , so now the best is IVIG (1 g/kg/d for 1-2 days & some times may be extended to 5 days & this usually induces a short-term increase in the platelet count, starting within several days and lasting approximately 2-3 weeks, but the problem with IVIg is that it's benefit is usually not long lasting & there's No clear evidence indicates that repeated infusions induce a lasting remission.
- So after you increased the PLT count with IVIg to



maintain the increased PLT we should put our patients on a potent immunomodulatory agent & the best is cyclic monthly pulses of Cyclophosphamide ( 750mg-1gm ) / pulse .

- After completing the 6 pulses of Cyclophosphamide you can maintain your patient on AZA 150 mg/ day .
- If cyclophosphamide failed to maintain remission an alternative is Rituximab, it has been reported to induce lasting remission in refractory Thrombocytopenia .
- Vincristine infusion (0.02 mg/kg) with a maximum dose of 2 mg every week for 3 weeks has also been shown to induce remission .
- Refractory cases has also been treated with the combination chemotherapy regimen used for low-grade non-Hodgkin lymphoma (6 cycles of cyclophosphamide, vincristine, and prednisone), with some success.

#### **Howaida Elsayed Mansour**

د أحمد يحيي As long as there is no bleeding this is ok, but please start revolade 50 mg (tablet once daily for one month ) + the previous regimen and ask for manual platelets count in the CBC not the automatic one but Never to give him platelets and he will respond if no response IVIG/ sandimmune is the best

ان شاء الله

**Omer Mala Ahmed** Thanks dear prof **Howaida Elsayed Mansour** for your always golden informative comments . As you know Revolade induce transit increase of PLT count ,what's your opinion to change the AZA to Pulses of Cyclophosphamide concurrently with the start of Revolade or IVIG ?

Why you prefer Revolade over the IVIG ? The uses of IVIG is not give more rapid response than daily oral Revolade?

Great regards

**Howaida Elsayed Mansour** Yes dr **Omer Mala Ahmed** because the platelate count is Zero...!! So cyclophosphamide is not a choice and IVIG is much more

expensive than revolade and the child may or may not respond on it...we have no time to trails here in this critical situation

**Omer Mala Ahmed** Thanks dear prof **Howaida Elsayed Mansour** , yes you're right In cases like SLE OR other arheumatological diseases if platelets is below 70000 it is advised to not give Cyclophosphamide only after it corrected with steroid or other drugs like IVIG or Revolade.

**Howaida Elsayed Mansour** Yes dr **Omer Mala Ahmed** also it is much better after pulse soluomedrol to maintain your patient on decadron ampouls IV/8 hours it is much better than oral steroids in ttt of thrombocytopenia + hydroquine and immuran 1-2 mg/kg

**Hanem Salama** when can i stop decadron prof Howaida Elsayed Mansour?

**Howaida Elsayed Mansour** You can keep her on decadron IV up to a month or if platelets count rises above 60,000 then you can shift to oral hostacortin 20-30 mg (with dose adjustments acc to other data of disease activity eg nephritis, carditis , ESR, CRP .....etc) of course + hydroquine and immunosuppressive

**Hanem Salama**

**Abdollah Gamal** Thanks د.أحمد يحيى إسماعيل for the case.

You should:

1-Order blood film and manual plt count

2-Consider plt transfusion with major bleeding only.

Management should be:

(A) 1st LINE: pulse steroid ... Done (induction).

AZA, CYC, Vincristine, MMF may be used as induction or

steroid sparing agents.

(B) 2nd LINE : IV Rh IG (anti-D) in Rh + pt (75 ug /kg/day) or IVIG in others ...(induction and maintenance) every 4 wks ....

(C) 3rd LINE : Rituximab 375mg/m<sup>2</sup>/wk for 4 weeks(induction)  
(off label)  
...if no response..... Go to :

(D)4th LINE Arrange for SPLENECTOMY.

3- Use Eltrombopag or Romiplostim... As a Maintenance ttt.

4- Danazol may be used in adult male or with non pregnant female.

N.B: some authors recommend using Eltrombopag or Romiplostim as induction ttt as well before rushing to splenectomy.

Thanks

<http://www.uptodate.com/.../hematologic-manifestations-of...>

## Case97

Omer Mala Ahmed

28 November 2016

🔄☐ Dears All

Kindly for your opinions

Here i see many cases with features of Cervical radicular pain ( most likely due to TOS ) but no evidence of Cervical rib or mass & normal cervical MRI .

Some times they not respond well to medical treatment & some physical exercises that I prescribe for them in the form of stretching.

Here also there's a known Cardio Thoracic surgeon that perform resection of first rib for these cases , some get benefit & some deteriorate more !!

What's your opinions regarding managing these cases ?

Please tag everyone that has experiences in managing these cases with great regard

•Eg: picture one of may cases that underwent resection of Rt first rib .





**Omer Mala Ahmed** Dear profs & doctors  
**Howaida Elsayed Mansour**, **Rageh Elsayed**, **Tamer Elfarahaty**, **Basant Esawy**, **Mona Mansour**, **Sherry Kamel**, **Aliaa Omar El-hady**, **Samarino Helal**, **Muhammad Dughbaj**, **Mohammed Hassan**, ....  
**Samarino Helal** Prof Dr **Abdelmoaty Afifi**  
**Mohammed Hassan** Good evening dear Dr **Omer Mala Ahmed**

Rehabilitation techniques have very useful effects especially:

- 1- stretching scalene muscles and pectoralis minor muscles
  - 2- myofascial release for these muscles
  - 3- manipulation s and mobilization are very effective
- Use pulsed ULS before these manipulations and stretching

**Omer Mala Ahmed** Dear dr **Mohammed Hassan** thanks for your information, please if you can post the pictures or procedure for every thing you mentioned with great regards



**Mohammed Hassan** Many cases improved by these maneuvers  
Like · Reply · 3 · 28 November 2016 at 22:02

**Mohammed**

**Hassan** <http://emedicine.medscape.com/article/316715-treatment>

Physical Medicine and Rehabilitation for Thoracic Outlet Syndrome Treatment &...

EMEDICINE.MEDSCAPE.COM

**Omer Mala Ahmed**

**an** <https://youtu.be/uLdMP67B0eo>



Scalene - Myofascial Release Technique

YOUTUBE.COM

Like · Reply · Remove Preview · 3 · 28 November 2016 at 22:09



**Mohammed Hassan** <https://youtu.be/xajKqHo5tec>



PNF to Release Scalenes

Learn to release neck and shoulder pain in our Medical Massage seminars integrating some of the most effective...

YOUTUBE.COM

**Mohammed Hassan** <https://youtu.be/v-ZM13q-0dc>



## Pectoralis Minor: Palpation, Manual Therapy and Stretch YOUTUBE.COM

[Like](#) · [Reply](#) · [Remove Preview](#) · [2](#) · [28 November 2016 at 22:15](#)

**Omer Mala Ahmed**

**Ahmed Ibrahim Hammad** Good evening Dr [Omer Mala](#)

**Ahmed** I am dealing with many many cases that have that C.P of TOS with no cervical rib or mass or band

**Ahmed Ibrahim Hammad** Sometimes it is only due to Scalene ms over activity , also tightness of Pectoralis minor , costoclavicular syndrome,etc

**Ahmed Ibrahim Hammad** TOS have seven subtypes

**Ahmed Ibrahim Hammad** and in cases not having cervical rib, MRI may not reveal the pathology

**Ahmed Ibrahim Hammad** you need CT with contrast or angiography or MRI brachial plexus

**Ahmed Ibrahim Hammad** intensive rehab is the first choice even in presence of cervical rib

**Ahmed Ibrahim Hammad** because the high rate of recurrence of symptoms

**Ahmed Ibrahim Hammad** even after rib resection due to organising haemtoma and fibrosis

**Ahmed Ibrahim Hammad** life style modification is a must

**Ahmed Ibrahim Hammad** weight reduction in obese patients

**Ahmed Ibrahim Hammad** and exercises for life

**Ahmed Ibrahim Hammad** combination of more than one pathology is a challenge

**Ahmed Ibrahim Hammad** I saw patients with disc prolapse or Z joint affection plus TOS

**Ahmed Ibrahim Hammad** TOS in older is more difficult than in youth

**Omer Mala Ahmed**

**Rageh Elsayed** Thanks dr **Omer Mala Ahmed** for your case I agree with my friend **Mohammed Hassan** regarding his management 1- Neurovascular manifestation of TOS needs surgical interference 2- beside medical treatment we need to educate the pt to correct faulty stati...[See more](#)

**Omer Mala Ahmed**

**Omer Mala Ahmed** Sorry dear dr **Rageh Elsayed** i have one question on your comment .

What you mean by neurovascular manipulations need surgery? Because all of my cases complain of radiculopathic pain just like that of cervical disc herniation but the pain is not severe like it but more persistent boring neurogenic pain , so you agree with this type of surgical intervention for all these cases ?

Great regards

**Rageh Elsayed** 1st line of treatment is conservative if failed esp with progressive neurovascular manifestation. As lower trunk medial cord affection or recurrent thrombosis this refers to vascular surgeon

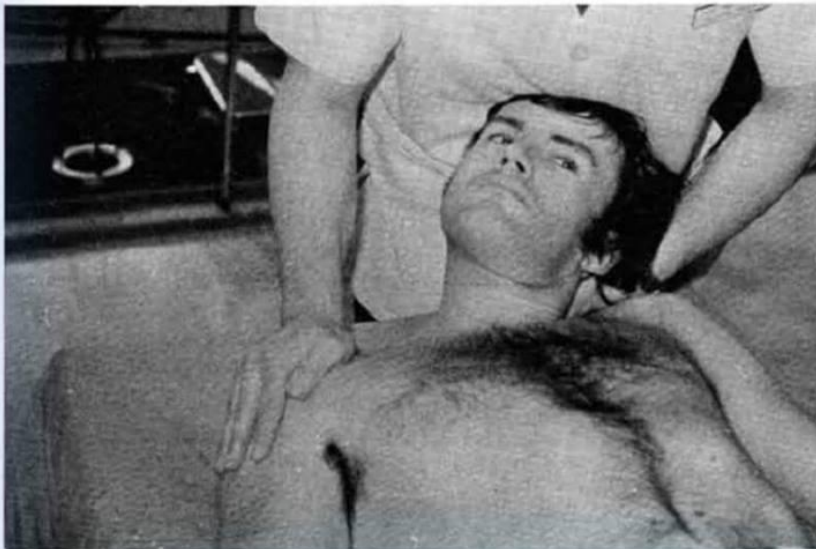
**Omer Mala Ahmed** **Rageh Elsayed** great thanks for your priceless information 🙌👍🌹👍

**Tamer Elfarahaty** Dear dr **Omer Mala Ahmed** . 1) Provocative tests for Neurogenic TOS may help u in diagnosis. 2 ) Neurogenic TOS due to poor shoulder girdle posture (no Cx rib & no vasomotor evidence ) . So we need first to remove aggravating factor : habitual carrying heavy objects ; avoid thick pillow ; prone position in sleeping ; sport habits (swimmer) and ergonomics modification. Any tension in scalene muscle results in elevation of 1st and 2nd ribs which lead to decrease size of thoracic outlet space. So, Our target to open thoracic outlet and increase elasticity of scalene muscle . A) Passive stretch

of both scalene & pectoralis .B)Increase anterior & posterior mobility of 1st &2nd rib. C) mobilization exc. for scapula &sternoclavicular joint. (all exc .need high experience and good training). 3) Graduated dose of pregablin as patient tolerability. 4); in a proximal root compression ;roule out also asdociated distal entrapment (Double crush) by NCV. 5) local anesthetic injection for trapezius muscles may be an option.

**Tamer Elfarahaty**

**N.B** The muscle stretching should always be done in a slow, gradual manner. Stretching of the scalene muscles should not be performed if there is an irritation of the brachial plexus in which traction on the plexus causes pain. **Deep sustained** pressure over the belly of the muscles can be used to induce relaxation. **The pectoral** muscles are the second group of muscles to be stretched



*Stretching of the scalene muscles. The Therapist's right hand is stabilizing the patient's shoulder.*

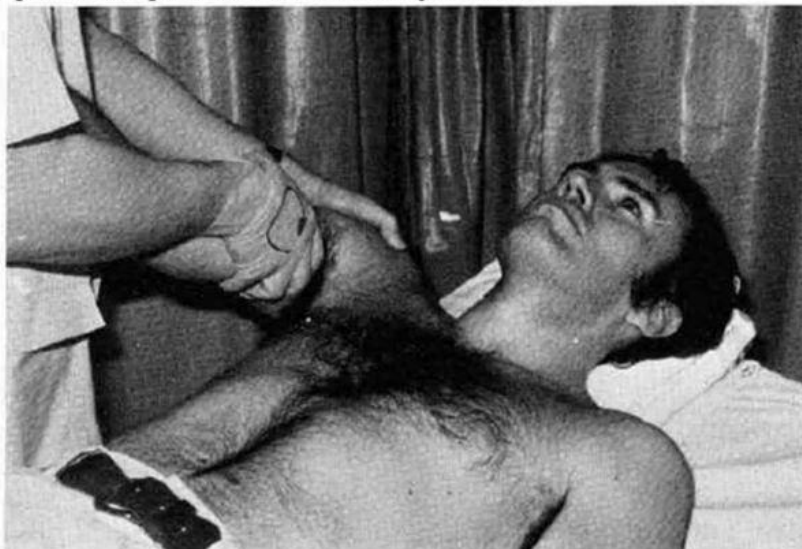
**Tamer Elfarahaty**



*Anterior articulation of the 1st and 2nd ribs. (Each rib is done separately.)*

**5- Massage of the shoulder girdle musculature.** A deep kneading massage is given to those muscles that have lost their elasticity due to muscle guarding and/or emotional tension.

**6- passive scapula-thoracic flexibility exercises.**



*Scapula-thoracic flexibility exercise that consists of a passive circular movement*

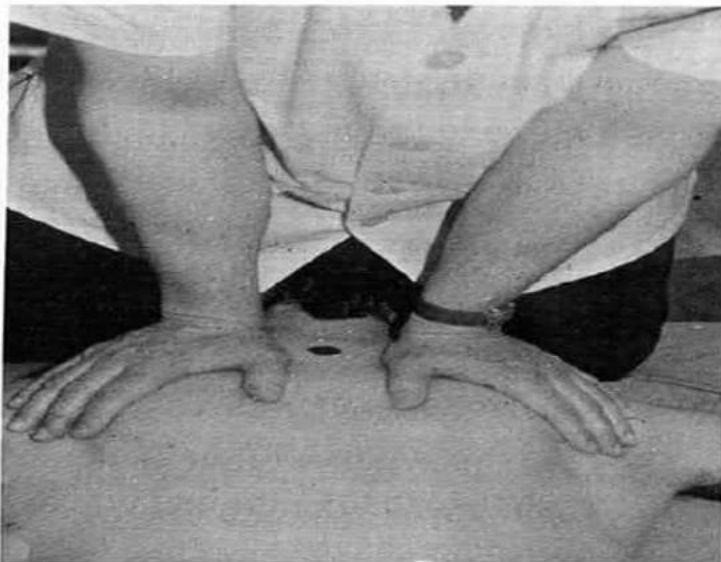
*Scapula-*

**Tamer Elfarahaty**





*Posterior articulation of the 1st and 2nd ribs on the right side with the cervical column locked. The therapist's left hand is maintaining the patient's cervical spine in left side flexion and right rotation. (Each rib is done separately.)*

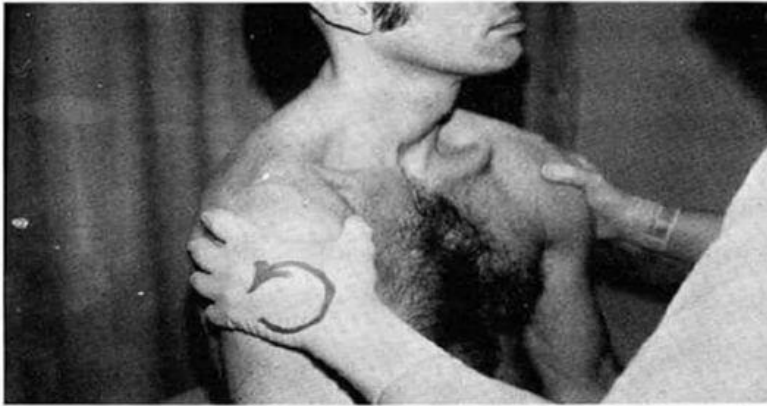


*Springing of the 1st and 2nd ribs creating a separational stress at the costovertebral joints*

[Tamer Elfarahaty](#)

### III) Home Program

#### 1- shoulder girdle circumduction exercise



2- The patient should not carry heavy objects (e.g., a heavy shopping bag) in the hand (or arm)

or slung over the shoulder on the affected side. If carrying a heavy object on the involved side is unavoidable, he should keep his shoulder elevated (shrugged) while carrying the object. The patient should also avoid physically stressful tasks that require pulling, pushing, or lifting with the affected arm

3- The patient should avoid sleeping on the affected side and in the prone-lying position. With the head on a pillow (especially a thick pillow), the cervical spine in the prone position is placed in forced rotation and hyperextension.

4- The patient is to modify occupational postural habits and body mechanics which precipitate or exacerbate his signs and symptoms.

5- For female patients, bra straps should not be tight and should be stretch straps. For the woman with pendulous breasts, a strapless longline bra may help diminish the patient's signs and symptoms.

6- The patient is to avoid physical activities that result in hard or rapid breathing. These activities may recruit the accessory breathing muscles (the scalene) which elevate the 1<sup>st</sup> rib.

7- The patient should avoid any activity that results in backward bending of the head or elevation of the affected arm over the head.

8- The arm should be positioned below shoulder level in rested position

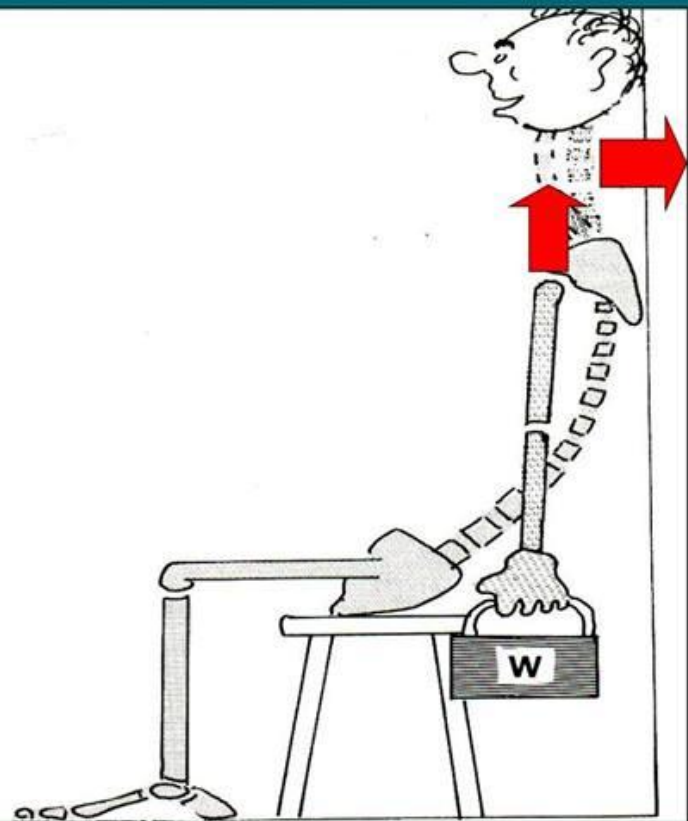
9- If the patient has an acute episode of his symptoms, instruct him to pull his shoulders up into the shoulder shrug position as far as possible and hold them in this position for 30-60

**Tamer Elfarahaty**

من محاضرة الأستاذ الدكتور صفوت العربي

Posture—Scapular elevation exercises  
Patient is seated with back to wall, his head & neck pressed against the wall, which decreases the cervical lordosis

With arms, fully extended & dependent, weights are lifted in a shrugging motion  
Weights vary from 5 to 30 pounds



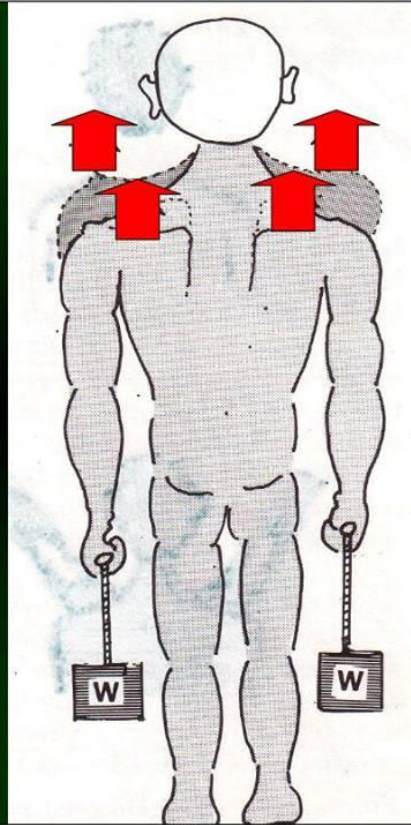
## Anterior Scalene Syndrome Scalene Anticus Syndrome

### Treatment

These exercises will also improve posture & opening of the cervical dorsal outlet

The same exercise is also performed in the  
**standing position**

Standing scapular  
 elevation exercises  
 With proper posture  
 ( tilted pelvis &  
 flattened cervical  
 lordosis ) both arms  
 are rhythmically  
 elevated , held &  
 slowly lowered  
 Increasing weights  
 are used  
 Elbows must be fully  
 extended



**Omer Mala Ahmed** Thanks allot for this Very informative  
 comment dear dr **Tamer Elfarahaty** .

So the elevation of the first rib can cause decrease of the  
 thoracic outlets?one time i asked this cardio thoracic surgeon  
 what you see in X-rays indicative of that the resection of the  
 first rib is useful in such cases? He said :

( slope of first rib more than 45 degree means for us either  
 drop shoulder if negative provokative test and TOS if postive  
 provokative testes and T1 in the lateral view is nearly  
 pasognomonic for TOS sor far for the same reason that the 1st  
 rib slope & at that time we may perform resection of the slopped  
 first rib )

As in this case we see inclination ( slop ) of first ribs  $> 45^{\circ}$





Ali Mursi was there myofascial pain?

Mona Mansour The best treatment is physically rehabilitation in form of stretching to the scalenii muscles, pectoral is major and minor preceded by local heat infrared or hot back



If it is neurogenic i.e associated with weakness C8 and T1 so you should exercise the muscles of the small muscles of the hand. Also give instructions to avoid repetitive over head activities e.g vocational as gardening or painting, avocational as water polo, volleyball and basket ball or during sleep. You can give nsoids and muscle relaxants for a short period during the start of physical therapy . Neurotonics and neuroleptics may be helpful too The response is great esp. If early I have treated allhamdollelah many cases and the results were great. For those who underwent surgery and they felt more pain after that, they are most probably had turned into complex regional pain syndrome, so the treatment as before plus treatment by mirror therapy . Also you can add calcitonin nasal spray for its effect on modulation of central pain and on the developing osteoporosis. The results are great and I had a case of TOS treated by rib resection and she had severe intolerable pain in her upper limb that made her to cry when touched plus weakness of small muscle of the hand. She recovered completely in one month 12 sessions plus home exercises and she invited me for her wedding party 😊👍.

## Case98

د. أحمد يحيى إسماعيل

9 December 2016 at 17:45

Dear profs,

Is there any problem with pulse solumedrol for a lupus nephritis with acute kidney injury, creatinine is 9?

Do we need adjustment? Pt isn't Overloaded.

**Like**

**Aliaa Omar El-hady** Howaida Elsayed Mansour Tamer  
Elfarahaty Mohammed Hassan Rageh Elsayed Omer  
Mala Ahmed Mona Mansour Sherry Kamel

**Fatemah Elshabacy** No dose adjustment is needed try to reduce amount of fluid you dissolve solu in and give it over very long period

**Howaida Elsayed Mansour** Dear dr د. أحمد يحيى إسماعيل  
Either it is acute or chronic kidney injury this patient needs haemodialysis at least 2 sessions even if she is not overloaded and no problem to give her 1gm pulse soluomedrol full dose but please give it to her after the 1st dialysis session so as not to be washed during dialysis...

**Hanem Salama** In lupus nephritis. I refer to dialysis with any elevation of s.creatinin?

What titre at which i ptn must to do dialysis proff Dr Howida

د. أحمد يحيى إسماعيل

9 December 2016 at 17:45

## Case99

Dear profs,

Is there any problem with pulse solumedrol for a lupus nephritis with acute kidney injury, creatinine is 9?

Do we need adjustment? Pt isn't Overloaded.

### 7Aliaa Omar El-hady, Omer Mala Ahmed and 5 others Comments

**Aliaa Omar El-hady** Howaida Elsayed Mansour Tamer Elfarahaty Mohammed Hassan Rageh Elsayed Omer Mala Ahmed Mona Mansour Sherry Kamel

**Fatemah Elshabacy** No dose adjustment is needed try to reduce amount of fluid you dissolve solu in and give it over very long period

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**Hanem Salama** In lupus nephritis. I refer to dialysis with any elevation of s.creatinin?

What titre at which i ptn must to do dialysis proff Dr Howida

## Case100

Nermeen Ahmed Foud

30 November 2016

Dear my professors and colleagues

I want to take your opinion about this case

male pt 54y complaining 5years ago of recurrent attacks of abdominal pain, polyarthralgias, generalized fatigue, shivering without fever, genital erythema with itching which leave crusts scalp pain and near the end of the attack tongue depapillation occur

these attacks last about 5 days and resolve with no specific ttt, recure every some months without any predisposing factors.

he has family history of overian carcinoma

screening for malignancies and FMF revealed nothing and he said that many labs were done and all were negative.

what's your opinion and how to proceed??



**Aliaa Omar El-hady** Profs. Howaida Elsayed  
Mansour Tamer Elfarahaty Omer Mala



[Ahmed](#) Mohammed Hassan [Rageh Elsayed](#) [Mona Mansour](#) [Ali Mursi](#) [Basant Esawy](#)  
[Aliaa Omar El-hady](#) His tongue looks like amyloidosis  
Like · Reply · [4](#) · [30 November 2016 at 18:59](#)

[Nermeen Ahmed Foud](#) his tongue loses its papillae only during the attack

[Aliaa Omar El-hady](#)

حالة غريبة

[RiRi Kamal](#) Following

[Heba Hassan](#) Following

[Omer Mala Ahmed](#) Dear Dr Narmeen  
Ahmed [Nermeen](#) thanks for sharing this case .  
The picture of the tongue goes with what's called Geographic Tongue (GT )  
Many causes could be behind the GT , as far as your case associated with abdominal pain; I advice you to consult an Gastroenterologist doctor because many bowel problems that cause impaired absorption of essential vitamins & Minerals may be behind the development of GT , also malabsorption of the essential minerals & vitamins may also behind his arthralgia & fatigue.  
But in the presence of Shivering without fever ?! We should think also about allergy to some food products that may be behind his complaint ( shivering & GT )

[Nermeen Ahmed Foud](#) he already had consulted an eminent professor of gastroenterology and also reached to nothing

[Basant Esawy](#) Agree with dr [Omer Mala Ahmed](#), this is geographic tongue  
During the attacks of shivering the fever should be documented or either it is psychological

Regarding genital erythema should be evaluated by  
Derma for possible viral infection ...[See more](#)

[Like](#) · [Reply](#) · [5](#) · [30 November 2016 at 22:30](#)

[Nermeen Ahmed Foud](#) many thanks my dear prof  
he already was seen by gastroenterologist and endoscopy  
was done and it was normal.

I also suggested TRAPs but it could occur at this age?

[Basant Esawy](#) [Nermeen Ahmed Foud](#) it occurs in  
younger and childhood but also some case can present  
the chch attack late in their life

[Nermeen Ahmed Foud](#) as I didn't do it before, I ask about  
(TNFR mutation)? is it done at the ordinary labs?

[Basant Esawy](#) I do not think so

I do it in biocencia lab Germany

[Nermeen Ahmed Foud](#) how to reach it dr [Basant Esawy](#)

[Basant Esawy](#) There is a contract with our hospital for  
unavailable labs and Biocencia

So you could ask in big laboratory I think some of them  
send those labs outside the country

[Nermeen Ahmed Foud](#) many thanks dear prof and sorry  
for overloading

[Basant Esawy](#) [Nermeen Ahmed Foud](#) you are welcome  
my dear

[Tamer Elfarahaty](#) This case with fissured tongue ;  
polyarthralgia & easy fatigability & recurrent abdominal pain  
and genital erythema need to rule out the following : 1) Sjogren's syndrome with fissured tongue complicated by  
malabsorption (celiac disease) with vit D deficiency; also  
may be associated with dyspareunia which may be behind  
genital erythema & itching ( for minor salivary gland  
biopsy & anti Ro & la) 2) IBD (chron's) with  
gastroenterologist consultation 3) viral infection Hepatitis C  
& HIV 4) amyloidosis 5) Malabsorption syndrome with vit D  
B12 & Iron def.

[Nermeen Ahmed Foud](#) many thanks sir, I will ask for labs you suggest

[Nermeen Ahmed Foud](#) many thanks for you all dear professors, I will follow your recommendation and updates you

[Howaida Elsayed Mansour](#) [Nermeen Ahmed Foud](#) I dont know why my mobile didnt show me the posts although you mentioned me....this is likely a case of behcet syndrome this is a tongue and the scare in the genitalia is likely genital ulcers abdominal pains and subclinical inflammatory bowel disease are very common in Behcet...DD polymyalgia rheumatica and giant cell vasculitis ( scalp pains) , CBC, CRP, ESR ...etc

## **Case101**

د.أحمد يحيى إسماعيل

28 December 2016 at 01:16

Dear profs,

Might I consult you for a case of 26 y.old SLE (not antiphospholipid)lupus nephritis class 4 pregnant female in the third trimester on prednisolone 10 mg , azathioprine 100mg , hydroxychloroquine 400 mg , aspirin , clexane 60/day.

She also receives isoptin 240 SR once as antiproteinuric agent.

Her proteinuria is 6 gm/day.

She developed mild exertional dyspnea & unexplained tachycardia ( although on isoptin , normal CBC and thyroid function). ECG: only sinus tachycardia. No signs of DVT. BP is normal.

D-dimer is 2.7 (normal upto 0.5).

How to exclude or diagnose pulmonary embolism and how to manage? How to approach tachycardia?

N.B.: Echo 7 bil.LL venous duplex are pending.

Thanks in advance.

**Abdollah Gamal** D dimer is usually elevated in normal pregnancy. So this pt. Should be investigated by other methods if she was suspected to have pulm. Embolism such as :

1- Pulm. function tests: VQ scan.

2-pulmonary angiogram MRA.

And ofcourse

3- Duplex studies on LL as u did.

As for Tachcardia,

Mild tachcardia is also normal in pregnancy. Howeve, Cardiac consultation and echo is recommended to investigate potential pathological causes.

Regards.

د.أحمد يحيى إسماعيل Tachy 126 while on isoptin 240 is significant.

**Abdollah Gamal** note that CCB per se increases HR also use of CCB as ttt for proteinuria is controversial and in my opinion should be discontinued.

**د.أحمد يحيى إسماعيل** Isoptin causes bradycardia , it is a treatment for tachyarrhythmias.

**د.أحمد يحيى إسماعيل** CCBs which cause tachy are amlodipine & nifedipine not verapamil.

**Abdollah Gamal** I agree, so what is the opinion of cardiologists?

**Abdollah Gamal** Any way, I would not use verapamil to control proeinuria

there are lots of conflicting data about it

**د.أحمد يحيى إسماعيل** Patient's BP was high , so it was for both BP & proteinuria instead of the usual use of aldomet.

**Abdollah Gamal** so preeclampsia must be ruled out.

**Abdollah Gamal** if before 30 wks kidney biopsy is recommended to differentiate between both

**Howaida Elsayed Mansour** Not kidney biopsy dear dr **Abdollah Gamal** just measure C3 and C4 if consumed this is lupus nephritis if they are not consumed this is likely preeclampsia vs renal vein thrombosis. ..

**Abdollah Gamal** Features of preeclampsia that help to distinguish it from active lupus nephritis are summarized below. These include a serum uric acid >5.5 mg/dl, a urine calcium level of <195 mg/day, and rising liver enzyme levels. Features of active lupus nephritis include a rise in dsDNA antibody titer, low or dropping complement levels , increased lupus activity in other organs, and an active urinary sediment. Complement-split products, such as C3a, may also indicate a flare, but their measurement is not routinely available. A renal biopsy may be needed to define the presence of active lupus glomerulonephritis.



| Clinical and Laboratory Features | Active Lupus          | Preeclampsia         |
|----------------------------------|-----------------------|----------------------|
| Hypertension                     | Onset before 20 weeks | Onset after 20 weeks |
| Proteinuria                      | >300mg/day            | >300mg/day           |
| Urinary sediment                 | Active                | Inactive             |
| Uric acid                        | <5.5mg/dl             | >5.5mg/dl            |
| Disk antibody levels             | Being                 | Stable or negative   |
| 24h urine calcium                | >100mg/day            | <100mg/day           |
| Complement levels                | >25% drop             | Normal               |

د.أحمد يحيى إسماعيل She is hypertensive & proteinuric before 20 weeks gestation , not preeclampsia.

د.أحمد يحيى إسماعيل I offered her rebiopsy but she refused , so we added azathioprine.

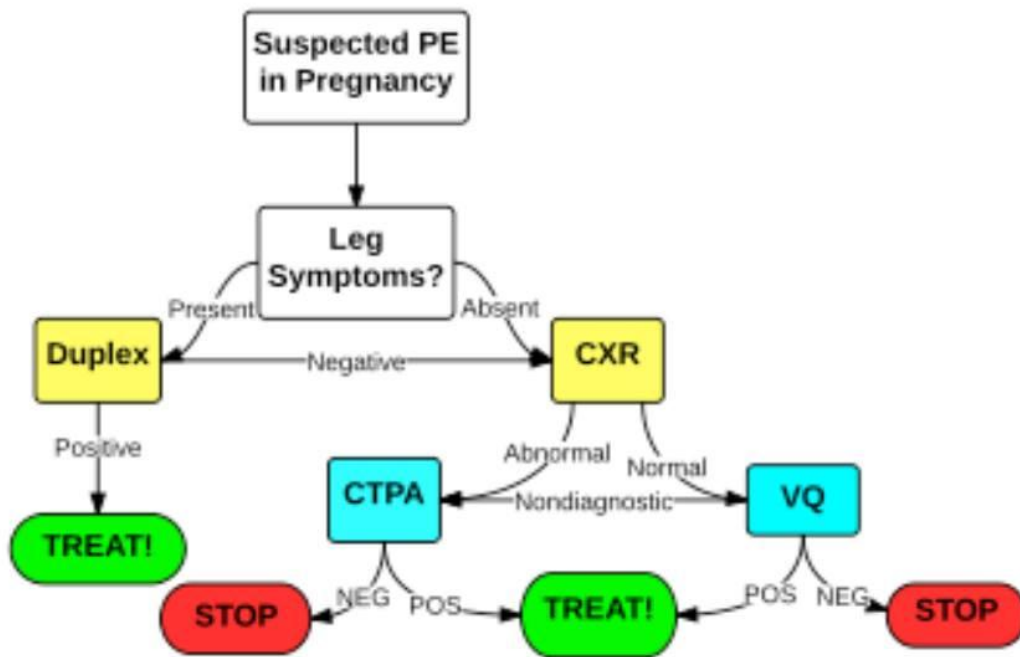
Abdollah Gamal it is difficult to differentiate although relatively recent tests were developed to help differentiate like : sFlt1 (soluble fms-like tyrosine kinase-1) and PlGF (placental growth factor) but I think they wont be available in Egypt.

Abdollah Gamal My opinion : this case requires multidisciplinary approach in which cardiologist and nephrologist must handle their side of the case.

د.أحمد يحيى إسماعيل Thanks for advice.

Abdollah Gamal welcome dear

د.أحمد يحيى إسماعيل American Thoracic Society Guidelines



**Basant Esawy** Echo Doppler cardiograph can help if there is rt ventricular strain you will suspect PE , pft and VQ scan  
D dimer good negative but not good positive

What about other lab as CBC and oxygen saturation?

Regarding lupus nephritis

Azathioprin better to optimize to 2.5 mg / kg

Prednisolon 20 mg will not pass through placenta

Doppler renal artery and vein to occlude thrombosis

C3 and c4 low in activity rather than preeclampsia

Plan for delivery as soon as 34 week with prophylactic shot of dexamethasone

This multidisciplinary approach with cardio , Nephro and obstetrician

Good luck

**Howaida Elsayed Mansour** This lady likely developed pregnancy induced dilated cardiomyopathy this explains dyspnea (likely due to pulmonary venous congestion not pulmonary embolism ) and tachycardia ( due to heart failure ) + this heavy proteinurea either due to aggressive lupus nephritis vs pre-eclampsia please do:

1- Echocardiography to assess for ejection fraction.

2- C3 & C4 if consumed this heavy proteinuria is due to lupus nephritis but if they are normal this it is likely due to pre-eclampsia or renal vein thrombosis...good you are properly anticoagulated your patient but time to stop aspirin (to avoid congenital PDA) and increase the dose of clexan to 60 mg twice daily.

3- lupus anticoagulant (LA) should be done for all lupus patient before pregnancy ..

4- Assess for hypertension that should be controlled by aldomet 250 mg 2x3 (this is very important and usually missed )

All this might be due to pregnancy before controlling disease activity...

5- Add diuretics if there is LL edema

6- add 1 gm pulse soluomedrol IV very slowly with 2 amp lasix if C3 , C4 found to be consumed and assess for the fetal movement and heart sound and try to deliver her as soon as possible ..

**Abdollah Gamal** Flares of SLE are likely to be associated with low or decreasing complement levels and increased titers of anti-dsDNA antibodies; by comparison, complement levels are usually, but not always, normal or increased in preeclampsia

**Abdollah Gamal** <https://www.uptodate.com/.../pregnancy-in-women-with...>

lters

## Pregnancy in women with systemic lupus erythematosus

UPTODATE.COM

**Abdollah Gamal** Features of preeclampsia that help to distinguish it from active lupus nephritis are summarized below. These include a serum uric acid >5.5 mg/dl, a urine calcium level of <195 mg/day, and rising liver enzyme levels. Features of active lupus nephritis include a rise in dsDNA antibody titer, low or dropping complement levels , increased lupus activity in other organs, and an active urinary sediment. Complement-split products, such as C3a, may also indicate a flare, but their measurement is not routinely available. A renal biopsy may be

needed to define the presence of active lupus glomerulonephritis.

DIFFERENTIATION OF PREECLAMPSIA FROM A LUPUS NEPHRITIS FLARE

The accepted definition of preeclampsia includes a blood pressure

1. Abstract and Introduction  
2. Pregnancy Outcomes in Systemic Lupus  
3. Risk Factors for Poor Pregnancy Outcomes

Table 6. Differentiation of Active Lupus Nephritis From Preeclampsia.

| Clinical and laboratory features | Active lupus nephritis | Preeclampsia         |
|----------------------------------|------------------------|----------------------|
| Hypertension                     | Onset before 20 weeks  | Onset after 20 weeks |
| Proteinuria                      | ≥300 mg/day            | ≥300 mg/dl           |
| Urinary sediment                 | Active                 | Inactive             |
| Uric acid                        | ≤5.5 mg/dl             | >5.5 mg/dl           |
| DNA antibody levels              | Rising                 | Stable or negative   |
| 24 h urine calcium               | ≥195 mg/day            | <195 mg/day          |
| Complement levels                | ≥25% drop              | Normal               |

Reproduced with permission from [114].  
Source: Expert Rev of Clin Immunol © 2012 Expert Reviews Ltd

Features of preeclampsia that help to distinguish it from active lupus nephritis are summarized in ( Table 6 ). These include a serum uric acid >5.5 mg/dl, a urine calcium level of <195 mg/day, and rising liver enzyme levels. Features of active lupus nephritis include a rise in dsDNA antibody titer, low or dropping complement levels (see earlier), increased lupus activity in other organs, and an active urinary sediment. Complement-split products, such as C3a, may also indicate a flare, but their measurement is not routinely available. A renal biopsy may be needed to define the presence of active lupus glomerulonephritis. If, however, the increased risk of bleeding following such biopsies in pregnancy is a consideration. On occasion, this diagnostic dilemma demands resolution with delivery of the fetus or a trial of empiric therapy.

**Abdollah Gamal** By the way, both conditions may have normal complement levels so Measuring C3, C4 and CH50 is useful as a positive test but if came normal then it can NOT rule out lupus nephritis.

Moreover, both conditions could coexist at the same time, that makes the differentiation even more problematic.

Prof. **Howaida Elsayed Mansour**

**Abdollah Gamal** Although the fact that most of NSAIDs should be avoided in pregnancy especially in the 3rd trimester, Low dose aspirin is recommended during pregnancy in recent guidelines and it does not cause PDA .On the contrary, it is often indicated to reduce the risk of preeclampsia and other obstetric-related indications.

<https://www.uptodate.com/.../use-of-antiinflammatory-and...>

prof. **Howaida Elsayed Mansour**

**Abdollah Gamal** As for kidney biopsy during pregnancy, this procedure can be performed safely by experienced operators in women with well-controlled blood pressure and normal

coagulation indices. It has been suggested that a biopsy may be performed if there is a sudden, unexplained deterioration in renal function or markedly symptomatic nephrotic syndrome occurring before 32 weeks gestation. Biopsy after week 32 is not recommended.

<https://www.uptodate.com/.../pregnancy-in-women-with...>

Prof. [Howaida Elsayed Mansour](#)

lterers

### Pregnancy in women with underlying renal disease

UPTODATE.COM

[Howaida Elsayed Mansour](#) Yes we can..

but no need for any invasive procedure during pregnancy...specially if C3 and C4 can be sufficient differentiating test...

[د.أحمد يحيى إسماعيل](#) Here is the last update.

[د.أحمد يحيى إسماعيل](#) Normal bilateral LL venous duplex

[د.أحمد يحيى إسماعيل](#) C4 consumed with normal C3

[د.أحمد يحيى إسماعيل](#) Echo. is normal.

[Howaida Elsayed Mansour](#) Start 1gm pulse soluomedrol and arrange to deliver her as soon as possible

د احمد يحيى  
اسماعيل



## **Case102**

د.أحمد يحيى إسماعيل

30 December 2016 at 23:14

Sorry for overloading , I have a 13 y. old female pt with lupus nephritis class V and proteinuria ~ 6.3 gm. I started Cellcept 2000 with prednisolone full dose ( gradually withdrawn , now on 15 mg/day) & hydroxychloroquine.

Her proteinuria is fluctuating but last result after 6 months is > 6 gm.

Also , her BP is low obligating me to decrease Tritace dose to 1.25 , even though, her BP is 90/60 with persistant headache.

My questions,

- 1.Would you recommend shift to cyclosporin? What is the dose esp. in this pediatric pt?
2. How to monitor cyclosporin level ? How frequent? and what is target level?
- 3.What might cause her hypotension?
4. Can I give her midodrine to control hypotension to be able to give ACEi ?!

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**Comment**

=

Aliaa Omar El-hady Howaida Elsayed Mansour Mohammed Hassan Mona Mansour Fatemah Elshabacy Amira Shahin Rageh Elsayed Tamer Elfarahaty

=

=

Elham Bermawy F

Abdollah Gamal Thanks for the case...

1-Blood pressure is not too low for her age and gender especially if she is thin (low BMI) so no need for adjustment ...

2- class V is usually benign in course so I think re-biopsy is recommended and if the results came back the same, then you should shift her to pulse CYC (NIH protocol) and give her GnRH before it.

3-I wouldn't recommend Cyclosporin due to high Toxicity

profile and nephrotoxic effect.

Regard

**Eman Thabet** F

**د.أحمد يحيى إسماعيل** I think CYC is more toxic esp. in a female child.

**Abdollah Gamal** Not at all

Especially in female children

Its toxicity is increasing with age

So the effect on ovaries is minimal in childhood

Moreover, Cyclosporin would cause more kidney damage than CYC

Also eular recommend shifting from CYC to MMF and vice versa if no response with any of them.

**Abdollah Gamal** P.S :FDA Approval of Midodrine had been Withdrawn in 2010

**Abdollah Gamal** CYC toxicity is increasing with age

So the effect on ovaries is minimal in childhood

Moreover, Cyclosporin would cause more kidney damage than CYC

Also eular recommend shifting from CYC to MMF and vice versa if no response with any of them.

**د.أحمد يحيى إسماعيل** EULAR EDTA guidelines for lupus nephritis 2013 :4.4. In pure class V nephritis with nephrotic-range proteinuria, MPA (MMF target dose 3 g/day for 6 months) in combination with

Oral prednisone (0.5 mg/kg/day) may be used as initial treatment based on better efficacy/toxicity ratio.

CY or calcineurin inhibitors (ciclosporin, tacrolimus) or rituximab are recommended as alternative options or for non-responders.

[Abdollah Gamal](#) I Agree: ( based on better efficacy/toxicity ratio) CYC vs Cyclosporin...

Personally I would go for CYC.

[Rusul Alsalami](#) her blood pressure is acceptable for her age watch out for CNS lupus on the count of persistant headaches. Class 5 LN patients who fail to respond to MMF should be switched to high dose IV CYC for 6 months " and that should work too if indeed there is a CNS involvement" thanks for sharing this case

| BLOOD PRESSURE CHART BY AGE |        |        |        |
|-----------------------------|--------|--------|--------|
| Age                         | Min    | Normal | Max    |
| 1 to 12 months              | 75/50  | 90/60  | 110/75 |
| 1 to 5 years                | 80/55  | 95/65  | 110/79 |
| 6 to 13 years               | 90/60  | 105/70 | 115/80 |
| 14 to 19 years              | 105/73 | 117/77 | 120/81 |
| 20 to 24 years              | 108/75 | 120/79 | 132/83 |
| 25 to 29 years              | 109/76 | 121/80 | 133/84 |
| 30 to 34 years              | 110/77 | 122/81 | 134/85 |
| 35 to 39 years              | 111/78 | 123/82 | 135/86 |
| 40 to 44 years              | 112/79 | 125/83 | 137/87 |
| 45 to 49 years              | 115/80 | 127/84 | 139/88 |
| 50 to 54 years              | 116/81 | 129/85 | 142/89 |
| 55 to 59 years              | 118/82 | 131/86 | 144/90 |
| 60 to 64 years              | 121/83 | 134/87 | 147/91 |
| SHARE WITH EVERYONE         |        |        |        |

[Abdollah Gamal](#) If you want to initiate cyclosporine so you should:

- 1-Do GFR and s. creatinin
- 2-tacrolimus is better in females to avoid gum hypertrophy and cosmetic catastrophe.
- 3- Dose 3-5 mg/kg/day in divided doses every 12 hours for 1-2 years

**Tamer Elfarahaty** maximize dose of cellcept . CYC in female below 20 years old has lower risk than older one , also use uro protocol every 2 weeks preceeding by lupron. In resistant cases ; rituximab is an option .

**Amg Amg Mai Sami**

**Omer Mala Ahmed** Thanks for sharing this interesting case dear dr Ahmed,  
From the EULAR recommendation the best treatment for Lupus nephritis ISN class IV is MMF or CYC .  
This patient treated correctly as always MMF preferable over CYC in pediatrics or Childbearing age females , but in this case despite using MMF still the patient has nephrotic range proteinuria & even partially not improved ! It means that MMF is failed to induce remission in this case & it's a time to shift to another drug like CYC ,AZA ,Rituximab .

To me the best way in managing this case is to use low doses of IV CYC + monthly pulse SoluMedrol for 6 months then shift to AZA with Steroid ( 15-20 mg oral ), iV CYC has very low risk of infertility in patients less than 20 years.

\* in one study premature ovarian failure occurred in all of those over the age of 30 years, one-half of those aged 20 to 30 years, and 13 percent of those younger than 20 years.\* don't think of anything (like infertility) except saving her life you can not have a baby without a mother....!!

\* Leuprolide injection sc 2 weeks prior to each Cyclo pulse decrease the rate of Cyclo induced infertility by 80% ,(it is the only drug mentioned in literature to guard against infertility in females), but this drug is expensive & not available always .

\* One of my Indian friends (consultant Rheumatologist ) told

me that you can use pregnyl 5000 2 wks before pulse for fertility , he said that i use it & i never faced infertility with Cyclo pulses , although its not mentioned in literatures. ( he said that it's only personal trial needs further workup) , so you can try it 😊😊

- totally agree with my colleagues that her blood pressure is still acceptable .

- still you afraid from using CYC ? So you have a very good alternative! Which is AZA 🙌👉 give her 3 pulses of Solumedrol ( 500-750 mg ) & put your patient on AZA + Prednisolone 15-20 mg/day , it's really a very effective drug for Lupus nephritis, I usually use it in my cases with a very good result. In a study of membranous lupus nephritis, 38 patients were treated with corticosteroids and azathioprine; after 12 months of treatment, 67% of patients had a complete remission and 22% had a partial remission, with only 11% resistant to treatment. [58] Long-term follow-up of 12 years showed 19 episodes of renal flares. Retreatment with corticosteroids and azathioprine showed similar responses.

- although it was found that Cyclosporine may be effective in Membranous LN but it has many side effects & personally I not use it for lupus nephritis.

- another alternative & last choice in this case is to use steroid + Rituximab.

**Howaida Elsayed Mansour** Dear dr **Omer Mala Ahmed** but this patient had class V not class IV lupus nephritis and class V (membranous LN) has poor response to CYC...

Cyclosporine with pulse solumedrol give a very good result in resistance class V lupus nephritis. ..+ larger doses oral steroid 20 mg daily and vit D

**Omer Mala Ahmed** Thanks prof **Howaida Elsayed Mansour** for your information, i am totally agree with you that Cyclosporin is effective in treating this case but really i have no experience with this drug because I not used it for my cases of LN actually because of many side effects accompanying this drug 😊😊  
This updated recent paper talking about the efficacy of



Cyclosporin & it revealed that Cyclosporin even superior to CYC in class V LN 👍👍

●●●● ASIACELL 10:12 PM 88%  
jasn.asnjournals.org

blockade.

Most treatment regimens studied for pure membranous lupus nephritis with nephrotic range proteinuria are based on successful therapies used for idiopathic membranous nephropathy.

For example, Austin *et al.*<sup>44</sup> randomized 42 patients with membranous lupus nephritis to three groups: cyclosporine for 11 months (on top of steroids), alternate-month intravenous pulse cyclophosphamide for six doses (also on top of steroids), and alternate-day prednisone alone. At 1 year, the cumulative probability of remission was 27% with prednisone, 60% with cyclophosphamide, and 83% with cyclosporine. Remissions occurred more quickly in the cyclosporine group, but there were fewer relapses in the cyclophosphamide group.<sup>45</sup> Similar data are available from small numbers of patients treated with tacrolimus monotherapy.<sup>46–49</sup> Two recent trials of

**Howaida Elsayed Mansour** Yes it is an excellent drug in refractory lupus nephritis specially in membranous type ...however it needs close monitoring of the renal functions and any rise in s.creatinine the dose should be decreased and if s.creatinine continue high the drug should be stopped ...but it gives an excellent results regarding resistance proteinuria in class V LN

**Howaida Elsayed Mansour** Dear dr احمد سماعيل

Resistant type V lupus nephritis respond well to prednisolone so add 1 gm soluomedrol monthly for 6 months either with cellcept 2 gm daily (as you done) or you have the choice to shift to cyclosporine 100 mg daily with pulse soluomedrol 1 gm monthly for 6 months then continue on cyclosporine + oral steroids but you should measure the base line urea and creatinine (before cyclosporine ) and to monitor the patient response by monthly check up of protein/ creatinine ratio and renal functions...additionally this patient should be anticoagulated by marivan 3 mg daily to avoid renal vein thrombosis in this heavy proteinurea....check for C3 and C4 consumption, the target is the minimum dose of cyclosporine to bring her into remission ( start by at least 100 mg one cap daily), Dont give midodrine at all...and No need for this very low tritace specially with cyclosporine ( as it might increase the renal insult) and every visit check her B1p if all failed. ..try plasmapheresis session this would be very effective or of course Rituximab if available. ...

**Abdollah Gamal** Eular recommendations :

1-initiate MMF or IV CYC euro protocole

2-shift from MMF To IV CYC and vice versa if no response in 3-4 months, partial response in 1 year or complete remission in 2 years.

3-rituximab and Cyclosporine are 3rd option.

4-although having comparable Remission rates with CYC, Cyclosporine has a very high incidence of relapse (10 times more than CYC) in refractory LMN(Lupus Membranous Nephritis).

5-IVIG is another option.

5-plasma exchange is indicated in RPGN (Rapidly progressive GN) Only.

Prof.[Howaida Elsayed Mansour](#)

[Omer Mala Ahmed](#)

[د.أحمد يحيى إسماعيل](#)

<http://ardbeta.bmj.com/.../07/30/annrheumdis-2012-201940...>

Joint European League Against Rheumatism and European Renal Association–European Dialysis and Transplant Association (EULAR/ERA-EDTA) recommendations for the management of adult and paediatric lupus nephritis

Objectives To develop recommendations for the management of adult and paediatric lupus nephritis (LN).  
Methods The available evidence was systematically reviewed using the PubMed database. A modified Delphi method was used to compile questions, elicit expert opinions and reach consensus. Results Imm...

ARDBETA.BMJ.COM

**[Omer Mala Ahmed](#)** Joint guidelines for the management of adult and pediatric lupus nephritis have also been issued by European League Against Rheumatism and European Renal Association-European Dialysis and Transplant Association (EULAR/ERA-EDTA). The EULAR/ERA-EDTA recommendations include the following [48] :

Any sign of renal involvement can be an indication for biopsy, which should be performed within the first month after disease

onset, preferably before the institution of immunosuppressive treatment

Use mycophenolate mofetil or or low-dose IV cyclophosphamide plus glucocorticoids as the initial treatment for patients with ISN class III–IV A disease

In patients with adverse clinical or histological features, cyclophosphamide can be prescribed at higher doses, while azathioprine is an alternative for milder cases

For pure class V lupus nephritis LN with nephrotic-range proteinuria, use mycophenolate mofetil in combination with oral glucocorticoids for initial immunosuppressive therapy

Patients who improve after initial treatment should receive mycophenolate mofetil or azathioprine for at least 3 years; patients who start on mycophenolate mofetil should continue on that agent

Patients in whom mycophenolate mofetil or cyclophosphamide therapy fails should be switched to the other agent or to rituximab.

## SECTIONS



## Pharmacotherapy for Lupus ...

samples. Some clinical evidence indicates that azathioprine, cyclophosphamide, cyclosporine, and chlorambucil are effective in reducing proteinuria. Mycophenolate mofetil may also be effective.

In a study of membranous lupus nephritis, 38 patients were treated with corticosteroids and azathioprine; after 12 months of treatment, 67% of patients had a complete remission and 22% had a partial remission, with only 11% resistant to treatment. <sup>[58]</sup> Long-term follow-up of 12 years showed 19 episodes of renal flares. Retreatment with corticosteroids and azathioprine showed similar responses.



**Mohammed Hassan** Difficult case dear Dr [د. أحمد يحيى إسماعيل](#)

I think you should turn to

- combined pulse solumedrol monthly+ pulse CYC euro lupus protocol...[See more](#)

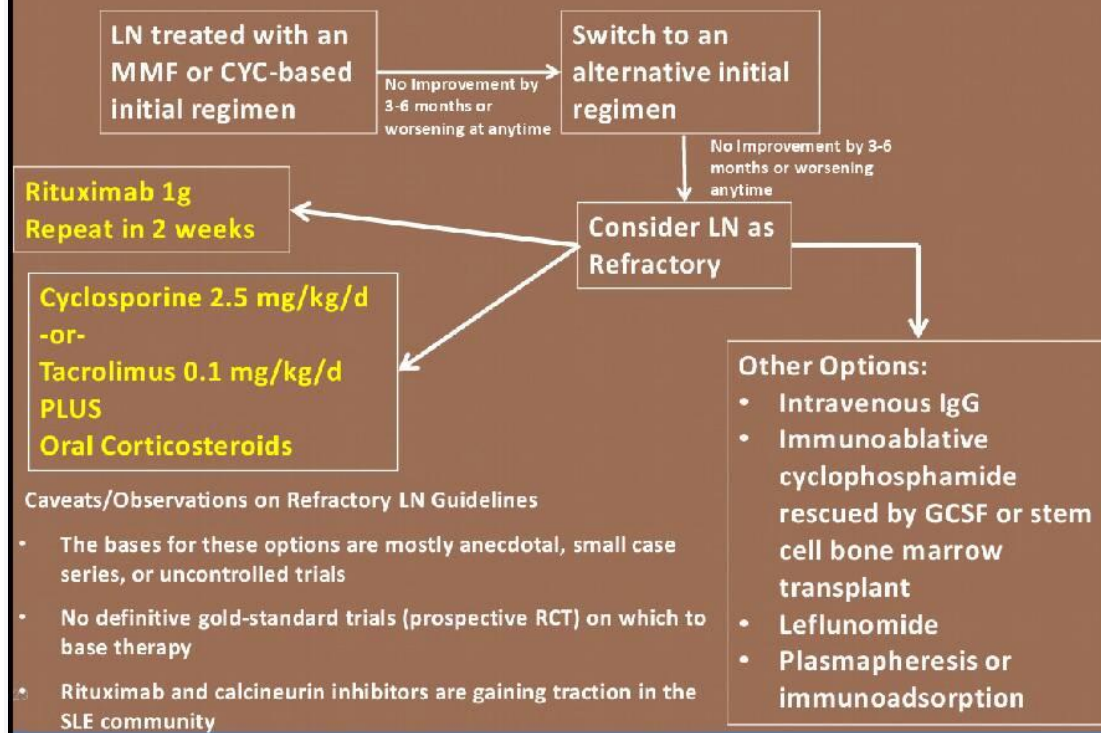
**Rageh Elsayed** thanks for sharing refractory case 1-start pulse cs + cyclo euro protocol dont afraid about fertility as incidence of fertility is very low 2- shift to AZA 3- if no response in lab better to shift to rutixumab

**Howaida Elsayed Mansour** But CYC is not the preferred immunosuppressive therapy in class V...Cellcept / Cyclosporine +pulse soluomedrol are the 1st choice in class V LN

**Rageh Elsayed** [Howaida Elsayed Mansour](#) dear prof , membranous LN is a special category associate with heavy proteinuria. This class of LN may be treated in different ways, according to the severity and other factors. These treatments range from isolated steroids to se...[See more](#)

**Tamer Elfarahaty**

## Therapy for Refractory LN-Based on 2012 Guidelines



Tamer Elfarahaty

## Expert Consensus Treatment Algorithm for SLE

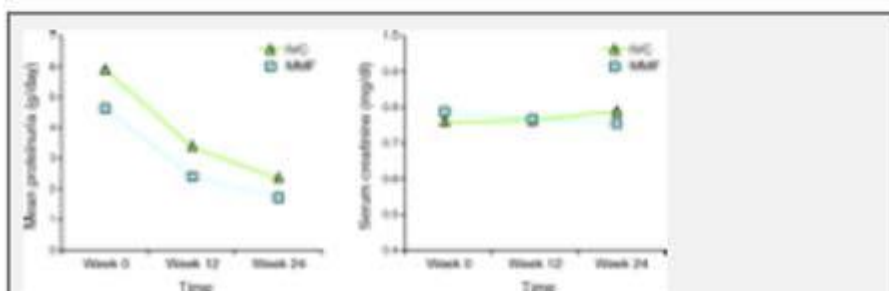
| Organ                 | 1 <sup>st</sup> Line | 2 <sup>nd</sup> Line          | 3 <sup>rd</sup> Line       | Agreement  |
|-----------------------|----------------------|-------------------------------|----------------------------|------------|
| Constitutional        | GC/HCQ/IS            | MMF                           | RTX/BLM                    | 60%        |
| <b>Widespread DLE</b> | <b>HCQ ± GC</b>      | <b>AZA/Δ<br/>Antimalarial</b> | <b>AZA/ MMF<br/>or MTX</b> | <b>70%</b> |
| Polyarthrititis       | HCQ ± GC             | MTX                           | RTX                        | 80%        |
| Pericarditis          | GC ± HCQ             | MMF/AZA/<br>MTX               | RTX/BLM                    | 75%        |
| Thrombocytopenia      | HCQ ± GC             | AZA/MMF                       | RTX/ IVIG/<br>IV CYC       | 50%        |
| CNS Lupus             | GC + IV<br>CYC       | RTX/IVIG/<br>Pheresis         | N/A                        | 60%        |
| Nephritis (III/IV)    | GC+ MMF              | IV CYC                        | RTX                        | 70%        |

Muangchan C, et al. Arthritis Res Ther 2015; 67:1237

**Omer Mala Ahmed** Updates on the Treatment of Lupus Nephritis:

Both Cyclophosphamide & MMF have similar efficacy in treating Class V lupus Nephritis

of patients treated with tacrolimus monotherapy.<sup>46–49</sup> Two recent trials of MMF *versus* intravenous cyclophosphamide induction in lupus nephritis<sup>24, 26</sup> included 84 patients with pure membranous lupus nephritis among the 510 patients enrolled. In a pooled analysis of these participants, remissions, relapses, and overall clinical course were similar in the membranous patients treated with oral MMF and intravenous cyclophosphamide induction therapy ([Figure 3](#)).<sup>50</sup> The previously discussed study by Bao *et al.*,<sup>32</sup> in which MMF was combined with a calcineurin inhibitor, lays out yet another potentially useful treatment regimen for cases of class V lupus nephritis associated with class IV proliferative lesions.



View larger version:

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**Omer Mala Ahmed** Updates on the Treatment of Lupus Nephritis:

From this recent study Cyclosporin is superior to CYC & steroid mono therapy in managing membranous lupus nephritis



blockade.

Most treatment regimens studied for pure membranous lupus nephritis with nephrotic range proteinuria are based on successful therapies used for idiopathic membranous nephropathy.

For example, Austin *et al.*<sup>44</sup> randomized 42 patients with membranous lupus nephritis to three groups: cyclosporine for 11 months (on top of steroids), alternate-month intravenous pulse cyclophosphamide for six doses (also on top of steroids), and alternate-day prednisone alone. At 1 year, the cumulative probability of remission was 27% with prednisone, 60% with cyclophosphamide, and 83% with cyclosporine. Remissions occurred more quickly in the cyclosporine group, but there were fewer relapses in the cyclophosphamide group.<sup>45</sup> Similar data are available from small numbers of patients treated with tacrolimus monotherapy.<sup>46–49</sup> Two recent trials of

[Amira Shahin](#) the regimens for LNgrade V are shared now. before starting any of them u should clarify the cause of hypotension in addition to persistent proteinuria. the three antiphospholipid abs. MRI abdomen with contrast to detect suprarenal abnormalities, IVC insults . fundus examination and MRI,MRV brain. can help.

[د.أحمد يحيى إسماعيل](#) ACR 2012 : Fertility issues are often a concern for young SLE patients with nephritis. In a discussion, the Task Force Panel recommended that MMF was preferable to CYC for patients who express a major concern with fertility preservation, since high-dose CYC can cause permanent infertility in both women and men (level A evidence of gonadal toxicity). Six months of high-dose IV CYC was associated with approximately 10% sustained infertility in young women, and higher rates in older women. If 6 months of CYC were followed by quarterly doses, there was a higher rate of infertility. The Task Force Panel did not reach a consensus on the use of leuprolide in patients with SLE receiving CYC as a means to preserve fertility. They also noted that MMF is teratogenic (class D in US Food and Drug Administration [FDA] ranking). Therefore, the physician should be sure that a patient is not pregnant before prescribing MMF or MPA, and the medications should be stopped for at least 6 weeks before pregnancy is attempted

[د.أحمد يحيى إسماعيل](#) ACR 2012 : Recommendations for Induction of Improvement in Patients with Class V "Pure Membranous" LN

The Task Force Panel recommends that patients with pure class V LN and with nephrotic range proteinuria be started on prednisone (0.5 mg/kg/day) plus MMF 2–3 gm total daily dose (level A evidence) (see Figure 3 in the original guideline document).

Other therapies for membranous LN have been reported;

however, the Task Force Panel did not reach consensus on a recommendation regarding those therapies.

د. أحمد يحيى إسماعيل KDIGO 2012 :Class V LN (Membranous LN)

The Work Group recommends that patients with class V LN, normal kidney function, and non–nephrotic-range proteinuria be treated with antiproteinuric and antihypertensive medications, and only receive corticosteroids and immunosuppressives as dictated by the extrarenal manifestations of systemic lupus. (2D)  
The Work Group suggests that patients with pure class V LN and persistent nephrotic proteinuria be treated with corticosteroids plus an additional immunosuppressive agent: cyclophosphamide (2C), or CNI (2C), or MMF (2D), or azathioprine (2D).

Abdollah Gamal If a calcineurin inhibitor is used, most experts treat with cyclosporine, starting at 100 mg twice daily. The dose is adjusted to achieve a trough level between 150 and 250 mcg/L and a reduction in proteinuria; the dose is reduced by 25 percent if the serum creatinine increases by 33 to 49 percent or by greater than 0.3 mg/dL (27 micromol/L) on two or more determinations.

In patients who are treated with tacrolimus rather than cyclosporine -to avoid gum hyperplasia and cosmetic issues esp. in females, we usually start with 1 to 2 mg twice daily to achieve a trough level between 5 and 10 mcg/L and a reduction in proteinuria, reducing the dose as needed if there is an increase in the serum creatinine.

If a clinical response is attained, we usually continue calcineurin inhibitor therapy for approximately two years, by which point, the drug dose is tapered and discontinued.

### Case 103

Omer Mala Ahmed with Aliaa Omar El-hady and 7 others.  
2 January at 22:35 · Ranya, Iraq

- 36 years old male patient presented to me complaining of bilateral medial side knee pain ,no swelling. He developed this condition recently after heavy military training.
- investigations : Normal
- X-Rays : posted below.
- For Your kind opinions





**Mohamed Magdy** What about examination of medial collateral ligament ???

Pes anserine bursitis

Examination of the Back , radiculopathy to both LL .

**Omer Mala Ahmed** Dear Dr **Mohamed Magdy**

Clinical tests for Both MCL pathology were normal.

The site of the pain near the joint line & not in the area of pes anserine bursitis ...[See more](#)



**Mohamed Magdy** What about the muscles ( sartorius , semitendinosus , gracilis ) may be strains of the tendons of these muscles

**Mohamed Magdy** So , I recommend to do MSK US , Antioedematous , NSAID may have a role for your case

**Aliaa Omar El-hady** It looks like stress fracture in tibial plateau

**Mohamed Magdy** Bilateral ???

**Aliaa Omar El-hady** Yes, bilateral due to vigorous exercise of military training...common

**Mohamed Magdy** I noticed it firstly but I exclude after seeing it bilateral

**Aliaa Omar El-hady**



Radiopaedia.org



## Bilateral proximal tibial stress fractures | Radiology Case ...

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**Aliaa Omar El-hady**

عارفاها لان زوجي مستشار العظام بالتجنيد والكلية الحربية...الشباب اللي بيدخلوا stress fracture الحربية بأي اعوجاج مع التمرينات ببيجي لهم

**Mohamed Magdy** So , Dr **Omer Mala Ahmed** , report this case as case report after doing CT

**Aliaa Omar El-hady**

common دي حالة case report مش محتاجة

**Tamer Elfarahaty** Also it may be artifact

**Tamer Elfarahaty** Site is not typical site of stress or avulsion fracture . Which be more higher and proximal ( just my suggestion)

**Omer Mala Ahmed** Dear Dr **Tamer Elfarahaty** thy are not artifacts because the patient has severe pain , also severe tenderness at the sites below the medial side joint lines

**Tamer Elfarahaty** Yes may be artifact and there is another cause behind pain. For me this a typical site for stress fracture . CT is mandatory in resistant pain

**Tamer Elfarahaty** Also request for radiology consultation . Rest from high impact or vigorous effort . NSAIDs and bilateral knee support .

**Tamer Elfarahaty** If there is Pain at medial joint line so What about test for meniscus; ACL injury & medial collateral ligament ?? Flat foot may put strain on knees?? Vit D deficiency ??

**Tamer Elfarahaty**

In the knee, the most common findings in examination was the knee shrug sign this is in accordance with findings from similar studies which have reported patellofemoral pain syndrome as the most common cause of knee complaints among military recruits. [26,27,28] An interesting finding in our study was the relative imbalance in findings when

[Tamer Elfarahaty](#)

Studies have related the high incidence of lower extremity overuse injuries in military recruits

[Aliaa Omar El-hady](#)



[Tamer Elfarahaty](#) May be look like trancluent line  
represent psudo fracutre of osteomalcia ??

[Tamer Elfarahaty](#) Lateral vei w xray??



[Omer Mala Ahmed](#) Sorry I not took the lateral views , if it's necessary i xan do it tomorrow

[Tamer Elfarahaty](#) May be chonomalcia patella with squatting effort or patellofemoral pain syndome (runner knee)

[Tamer Elfarahaty](#) Also see any abnormality of patella like patella baja

[Omer Mala Ahmed](#) Thanks my dears [Mohamed Magdy](#) & [Aliaa Omar El-hady](#) for your nice & informative comments . Yes it goes with bilateral tibial plateau fracture

[Aliaa Omar El-hady](#) Thanks Dr. [Omer Mala Ahmed](#) for your nice case



[Tamer Elfarahaty](#) Also roule out plica syndrome as pain at medial side but bliaterality may be against it

[Aliaa Omar El-hady](#)



JBSR



## Bilateral Synchronous Stress Fracture of the Tibia in a Young ...

Bilateral Synchronous Stress Fracture of the Tibia in a Young Female Basketball Player

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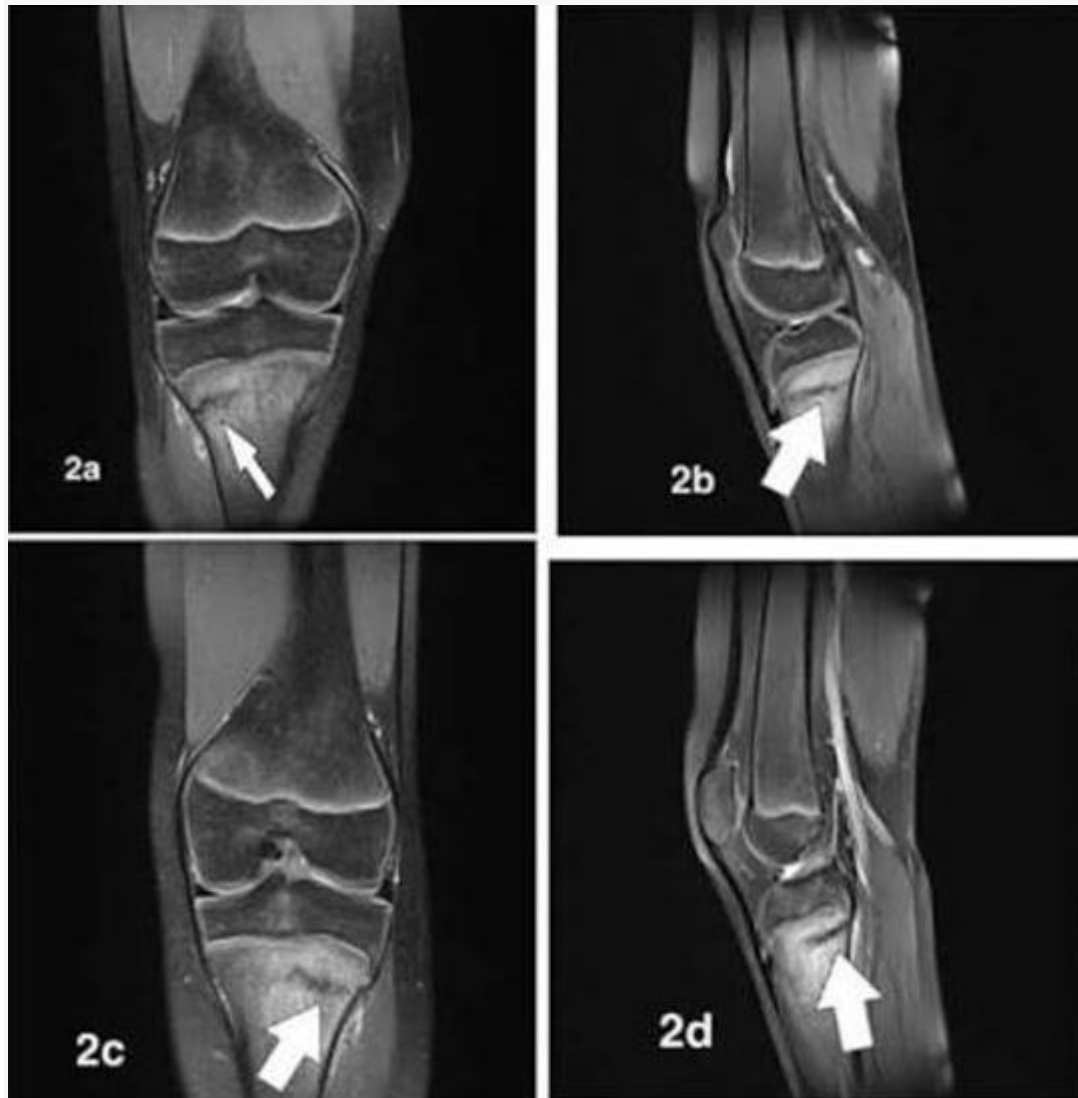
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[Aliaa Omar El-hady](#)



JBSR



Bilateral Synchronous Stress  
Fracture of the Tibia in a Young ...

Fig02\_web.jpg

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[Aliaa Omar El-hady](#)



[Omer Mala Ahmed](#) This CT scan exactly looks alike my case

[Tamer Elfarahaty](#)

In the knee, the most common findings in examination was the knee shrug sign this is in accordance with findings from similar studies which have reported patellofemoral pain syndrome as the most common cause of knee complaints among military recruits. [26,27,28] An interesting finding in our study was the relative imbalance in findings when

[Tamer Elfarahaty](#)



In conclusion and based on our results, we believe that action is needed to reduce the rate of lower extremity injuries in military recruits in Iran; we suggest that training be adjusted according to risk stratification and we also recommend that a redesign of the military boots is undertaken to

[Omer Mala Ahmed](#) Nice information my dear dr [Tamer Elfarahaty](#) , so we put patellofemoral pain syndrome as a DDx .

[Tamer Elfarahaty](#) Yes bside stress fracure . My advice requset vit D also . This translucent line may be pseudo fracture of osteomalcia? Or may be vit d deficiency induced stress fracutre with over use

[Tamer Elfarahaty](#)

complaints of military recruits may not affect their ability to complete the military training course or have long-term health effects on them; in a follow-up study 10 years following the report of tibial stress fracture in military recruits in United States, no patient reported any discomfort or limitation relating to the tibial stress fracture they sustained while in training 10 years prior. These studies suggest that while there is a need to address the immediate

[Tamer Elfarahaty](#)

to several factors; these include muscular fatigue, load carriage, military boots, hematological and inflammatory factor and pre training level of fitness. The incidence of overuse injuries in military recruits has in turn been shown to reduce the load carrying capacity of the recruits and their overall physical readiness which are major concerns in an active duty military and thus necessitate

[Tamer Elfarahaty](#)

(95% CI: 0.09-0.32). Our findings are consistent with similar studies performed in other countries which have pointed out foot stress fracture as the most common injury incurred during military training.

**Tamer Elfarahaty** Stress fractures are most commonly affect foot although knees may be involved

overall health.[2,3,4,5,6] The most common lower extremity injuries noticed in military training are stress fractures which commonly affect the foot, although other bones of the lower extremity are also frequently involved. The most common complaint in people with stress fractures are localized pain in the lower extremity.[7,8] Other common complaints among military recruits include knee and back pain.

[Tamer Elfarahaty](#)



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[Tamer Elfarahaty](#)

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**Tamer**

**Elfarahaty** <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3929018/>



Effects of 8 weeks of military training on lower extremity and lower back clinical...

NCBI.NLM.NIH.GOV

**Tamer Elfarahaty** <https://www.vitamindcouncil.org/new-military-study.../>



Vitamin D Council | New military study underway looking to prevent stress...

VITAMINDCOUNCIL.ORG

**Tamer**

**Elfarahaty** <http://militarymedicine.amsus.org/.../MILMED-D-16-00115>

Need for Routine Vitamin D Screening in Military Personnel | Military Medicine -...

MILITARYMEDICINE.AMSUS.ORG

**Tamer Elfarahaty**

Vitamin D is a necessary component in repairing bone damage, decreasing predisposition to bone injury, and strengthening the immune system. Vitamin D deficiency plays a key role in the etiology of bone pathologies such as rickets, osteoporosis, and osteomalacia. In military personnel, as noted by the Deployment Health Clinical Center, low vitamin D blood levels have been associated with musculoskeletal injuries and stress fractures as well as implicated in increased susceptibility to chronic musculoskeletal pain, autoimmune disease, cancer, immune system dysfunction, diabetes, and post-traumatic stress disorder—mild traumatic brain injury symptoms.

**Tamer Elfarahaty**

A team of researchers from the U.S. Army Research Institute of Environmental Medicine has partnered with the Trainee Health Surveillance Flight 559<sup>th</sup> Medical Group's Basic Military Training Team in Lackland, Texas to determine if increased vitamin D and calcium intake can improve bone health in military personnel.

Stress fractures and other bone and muscle injuries are among the most common causes of delay in basic military training. Five percent of males and 20% of females may experience a stress fracture during training. This causes trainees to miss valuable military training and sometimes can lead to drop out from the program.

**Tamer Elfarahaty**



## **High serum 25-hydroxyvitamin D is associated with low incidence of stress fractures.**

J Bone Miner Res. 2011 Jun 22. doi: 10.1002/jbmr.451.

Burgi AA, Gorham ED, Garland CF, Mohr SB, Garland FC, Zeng K, Thompson K, Lappe JM.

Naval Health Research Center, San Diego, California.

**BACKGROUND:** Low serum 25-hydroxyvitamin D [25(OH)D] concentrations are associated with hip fractures, but the dose-response relationship of serum 25(OH)D with risk of stress fractures in young women is unknown.

**OBJECTIVE:** This nested case-control study in a cohort of female Navy recruits was designed to determine if those with low prediagnostic serum 25(OH)D

[Omer Mala Ahmed](#) Priceless informations dear Dr [Tamer Elfarahaty](#), Great Regards for your help in managing this case 🙌👍🌸🌹

Like · Reply · [1](#) · [3 January at 11:09](#)

**Omer Mala Ahmed** **Rageh Elsayed**

**Rageh Elsayed** Thanks dear **Omer Mala Ahmed** and my colleges for nice brain storming discussion 1- I agree with my colleges regarding DD many causes can cause such complain 2- I find the patella is severely shifted upward and laterally with indicates bad muscle imbalance so we have weak contracted ITT and G medius and overacting adductors which is chronic and can be manifested by recent repetitive activity 3- in persistent knee complain can not be justified we must exclude proximal or distal mechanical problem like hip or feet abnormalities like pes planes with pronation is very common cause of such presentations 4- also here in Ksa osteomalacia is very common must be excluded and usually is also associated with shin splint

**Omer Mala Ahmed** Thanks dear Dr **Rageh Elsayed** for your informative comment, this is about the patella , what's your opinion about the fracture like lines in the medial side of proximal tibial physis ?

**Rageh Elsayed** **Omer Mala Ahmed** ok CT of the knee and vit D if free it is mechanical source find it

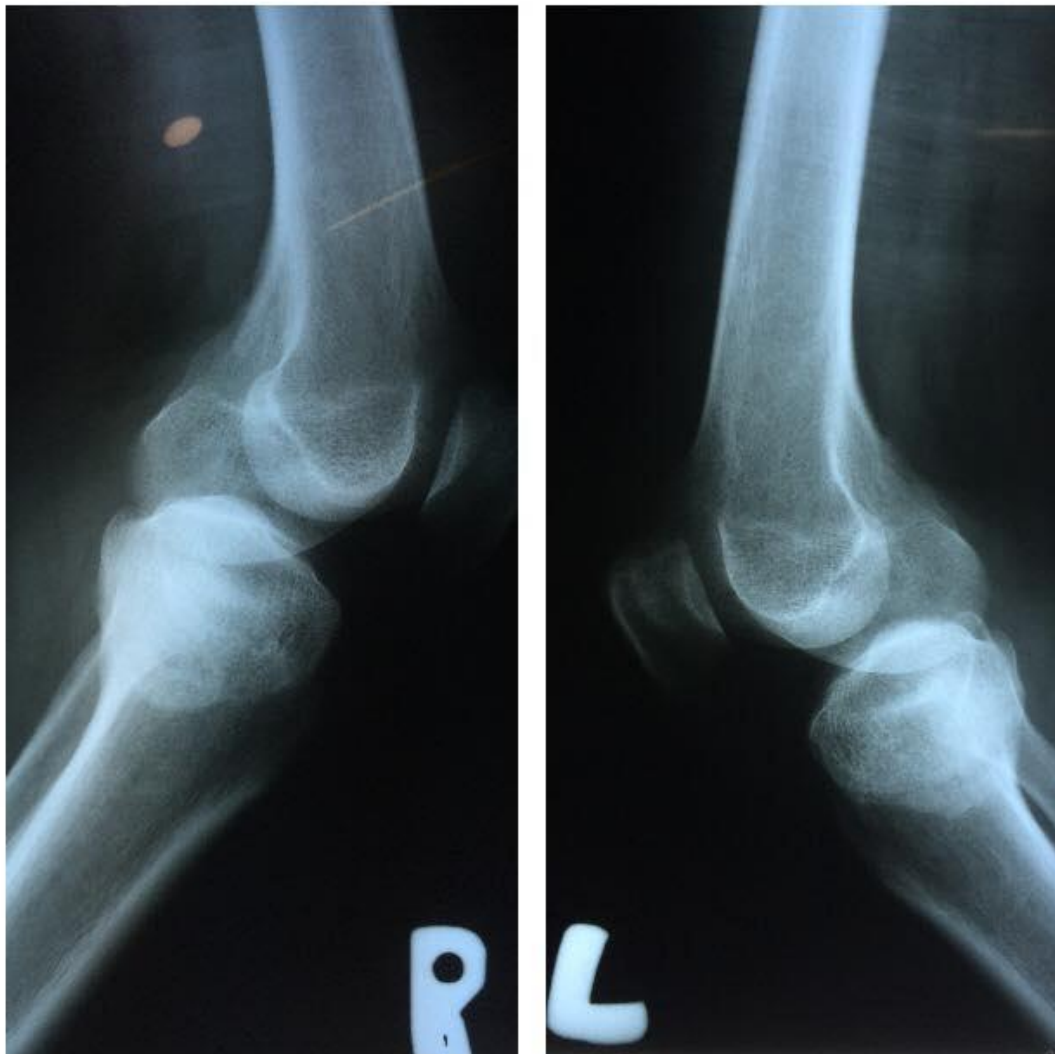
**Omer Mala Ahmed** Thanks allot dear Dr **Rageh Elsayed** for this big information 🙌👍🌸🌹

**Tamer Elfarahaty** Yes ITB syndrome is also common with runner ; but it present with lateral knee pain (not medial as in this case) higher at its origin or lower at aatachment with lateral femoral condyle .

...

**Omer Mala Ahmed** Updates regarding this case :

- S.Vit D : 12.3 ng/ml
- S.Ca : 8.9 mg dl
- S.ALP : 98 U/L ( N : 40-129 )
- sent for knee CT scan
- Lateral view Knee X-rays:



**Mohamed Magdy** There is any pain in quadriceps ms

**Omer Mala Ahmed** No

Unlike · Reply · [1](#) · [3 January at 22:29](#)

**Mohamed Magdy** From experience , vit D deficiency cause pain in this area as first manifestation

**Tamer Elfarahaty** 1) So first possibility is vit D deficiency induced stress fracture or with radiological pseudo fracture (looser line) for vit D 3 50000 IU po weekly for 2 to 3 months followed by vit D 3 2000 IU/day . Knee support & reassurance 2) runner syndrome although patellofemoral joint in xray is normal especially if pain increase with squatting or descending stairs . For quad strengthening exc & stretching ex for hip ;knee and calf muscle 3) i think patella is lower than normal in left side look like patella Baja ( need opinions of our colleagues) may be post traumatic ; but iam not sure as it is more obvious in lateral view with knee flexed 30. Examine quadriceps power 3) lastly examine foot for pes planus & over pronation which may put strain on knee and aggravate any knee pathology and need Shoe modification or orthosis . Good luck

Like · Reply · [2](#) · [4 January at 18:31](#) · Edited



**Ahmad Saad** Stress fracture in bil tibial plateau

Like · Reply · [1](#) · [4 January at 17:57](#)

## **Case105**

نسمه صلاح سالم

8 January at 20:56

السلام عليكم

كنت حابة أستشير حضراتكم في الحالة دي

Male patient, 65 years old  
chronic kidney disease on dialysis

S.creat 4.5

S.uric acid 13.5

Diabetic

Elevated liver enzymes

With the complete picture of chronic tophaceous gout

What about dose adjustment of colchicine and

febuxostat

Thanks in advance

**Samarino Helal** f

**Sherry Kamel** As patient on dialysis, so no need for dose adjustment

نسمه صلاح سالم

شكرا د/شيري



## Case106

د. أحمد يحيى إسماعيل

9 January at 14:56

A 26 yo SLE pt presenting with disorientation 2 weeks , fits and now developed suicidal attacks with fever , admitted in fever hospital And they say that CSF reveals no infection and she was referred to us yesterday with this severe agitation and suicidal attacks.

HVGB: 7.94 WBCs :8, lymph 1.2 , PLT 142

ANA+ve , dsDNA +ve ,pancytopenia, lymphopenia

CRP+++++,192

MRI brain , EEG : normal.

ESR is pending.

C3, C4 , Coomb's test are pending.

Questions : 1) Are there tests that can readily distinguish lupus cerebritis from CNS infections?

2) This very high CRP can't be explained by lupus activity or viral infections. What is your opinion?

د. أحمد يحيى إسماعيل Profs. Howaida Elsayed

Mansour Mohammed Hassan Mona Mansour Fatemah

Elshabacy Amira Shahrin Rageh Elsayed Tamer

ElfarahatyOmer Mala Ahmed

Tamer Elfarahaty High Procalcitonin may be better than CRP to rule out infection & also high C3; 4, leucocytosis in infection in contrast to low level of c3 ,4 ;leucopenia during activity . Anti DNA also correlate to disease activity . Antiribosomal ab increase i...[See more](#)

Sherry Kamel Dear dr .CBC feature ,leucopenia , pancytopenia is feature of activity ,not infection ,although some infection can cause leucopenia but not pancytopenia

Of course complement level can differentiate between

both activity and infection with other marker as dr .Tamer Elfarahaty mentioned

**Sherry Kamel** It is serious case need aggressive treatment , Endoxan pulse , steroid pulse and only for prophylaxis you can do these under umbrella of antibiotics till all pending investigation be done

**Amg Amg** Dear prof. Dr Sherry isnot pulse solumedrole enough to control the case ? Why we add endoxan , and what the reigemine to continue if we start it?

**Sherry Kamel** According to ur following up, you may not need to use endoxan again or you have to use it like course of LN

**Howaida Elsayed Mansour** Amg Amg Endoxan is the number 1 drug in induction of remission in lupus cerbritis and yes if your patient improves you should keep her on monthly endoxan for 6 months to maintan her remission ...otherwise she will flare up again...

**Howaida Elsayed Mansour** Dear dr د.أحمد يحيى إسماعيل  
This is a case of aggressive neuropsychiatric lupus ie lupus cerbritis dont waste more time, start now induction of remission by 1 gm soluomedrol daily for 3 days to be followed by 800 endoxan + hydroquinone 200 mg 1×2 followed by oral 30 mg hostacortine vit D and Ca this is a classical neuro- lupus presentation  
+ concomitantly consultant pschiatrist for antidepressants drugs to control the suicidal tendency if you can- do urgent MRI but if it is not possible for any reason start ttt immediately

**Samah Rashad** Dr.Noha Dadour  
**Dr.Noha Dadour**

عارفه بتفكرى فى ايه

**Howaida Elsayed Mansour** Even if the CRP is very high - as in this case ....even if there is ongoing infection...dont wait it is life saving ...start induction of remission of an aggressive lupus cerbritis by pulse therapy here the pulse therapy has a paradoxical effect on infection ... ie will help

in control of infection and not the reverse. ..as lupus patients are liable for infection due to active disease and so when you control the disease activity you help in controlling the infection ....ie soluomedrol and edndoxan here will help to control infection (not spreading of infections) as they control luous disease activity which is the cause of infection....+ concomitant use of broad spectrum antibiotics IV thats was what I do in my cases and this was also acc to Michel petry recommendation

**Mohammed Hassan** Totally agree with prof Dr **Howaida Elsayed Mansour**

This is life threatening state needs aggressive ttt  
Compiled Solumedrol and endoxan pulse with umbrella of good antibiotic with CA and vit D

**Mohammed Hassan** Don't wait for other inv results  
Start at once

**شيماء كامل** **Mai Abd Elfatah**

**Omer Mala Ahmed** Thanks dr Ahmed for your cases sharing

Totally agreed with my dear profs & colleagues that this patient has NPSLE especially in the presence of parameters of lupus flare in this case , the diagnosis of NPSLE is mainly clinical rather than through investigations

Yes as dear prof **Howaida Elsayed Mansour** said it's an emergency life threatening situation especially in the presence of suicide attempts, so need urgent treatment with 3 consecutive Solumedrole pulses+ IV broad spectrum AB ( please take a sample blood for culture& sensitivity before AB therapy to be return with in these 3 days during the steroids pulses therapy because with flares usually there's high possibility of infection especially in the presence of very high CRP titer ) , if the Blood

Culture returned negative directly start Cyclophosphamide pulse therapy after steroid pulse therapy.

In addition to HCQ + Oral steroid 20-30 mg+ Asprin 100mg / day all are useful drugs for NPSLE .

If the patient not showed any significant changes please start a IVIG or plasma exchange to abort this condition.

Also Retuximab found effective in resistant NPSLE.

**Rageh Elsayed** Thanks dear د احمد يحيى yes agree with my colleagues and prof regarding this rheumatological emergency regarding acute NPSLE usually it takes time to control about 6 months needs close monitoring and psychiatric inpatient unit

for fast acting drugs rutiximab is a good choice

**Waleed Salah** interesting case dr Ahmed, this is a very important question that rises to differentiate between activity with major organ affection and infection. i think this case is neuropsychiatric SLE, in such cases the best solution in my opinion that worked in many cases is to give pulse steroids under umberlla of antibiotics and avoid immunosuppressive medication untill infection is excluded and if there is improvement after steroid pulse you can added cyclophosphamide to your regimen

**Howaida Elsayed Mansour** The immunosuppressive here will control the infection ...why ? bec it will supress the disease activity returning the patient immune system back to the normal track in defending infection and not the reverse as most people think...

**Waleed Salah** i think other parameters can help to confirm the diagnosis and rule out infection like complement MRI spectroscopy and you may need even lumbar puncture if infection is highly suspicious

**Howaida Elsayed Mansour** Dear all the immunosuppressive here will control the infection ...how !? bec it will supress the disease activity (the original cause

of infection ) so returning the patient immune system back to the normal track in defending infection and not the reverse as most people think...

**Rehab Salem** Did the patient receive corticosteroid before these symptoms??

**Howaida Elsayed Mansour** I think No are u thinking in steroid induced psychosis ??

**Rehab Salem** yes

**Howaida Elsayed Mansour** If you have cold dont search for other reason for the running nose...



## Case107

Omer Mala Ahmed

10 January at 23:23

♻️♻️ 18 years old female patient complaining of low back pain & stiffness & sciatica.

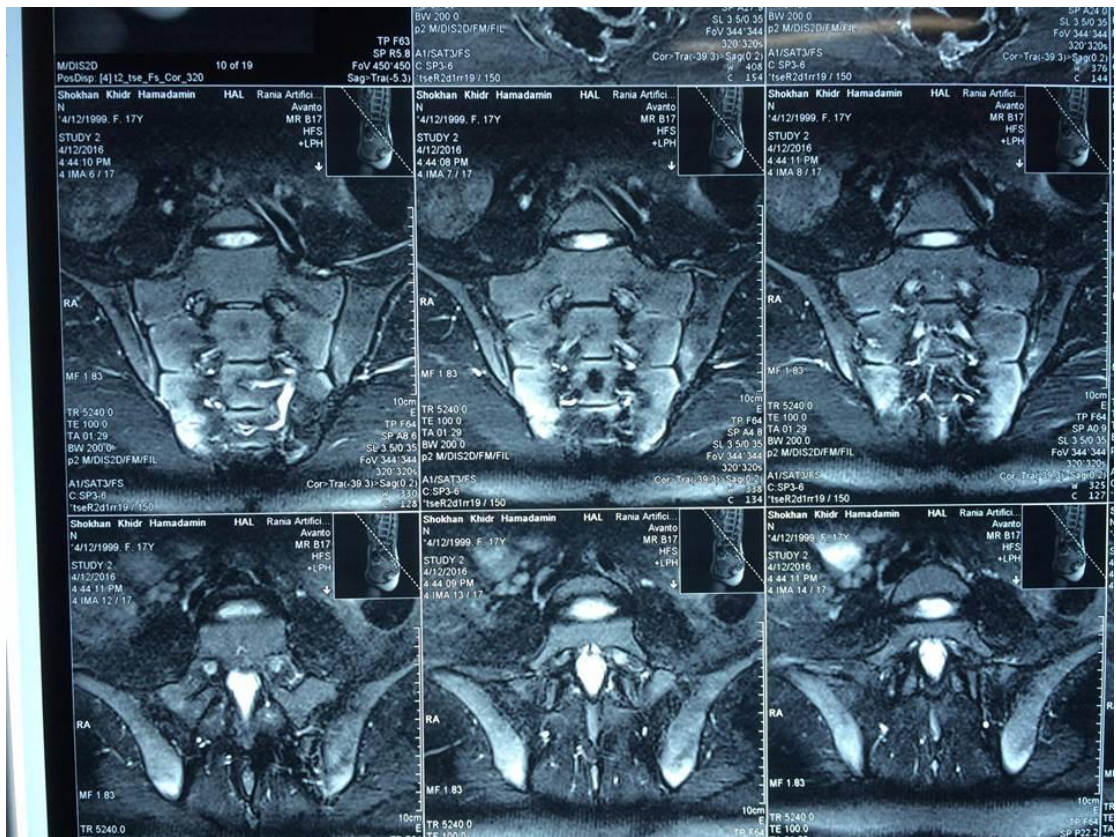
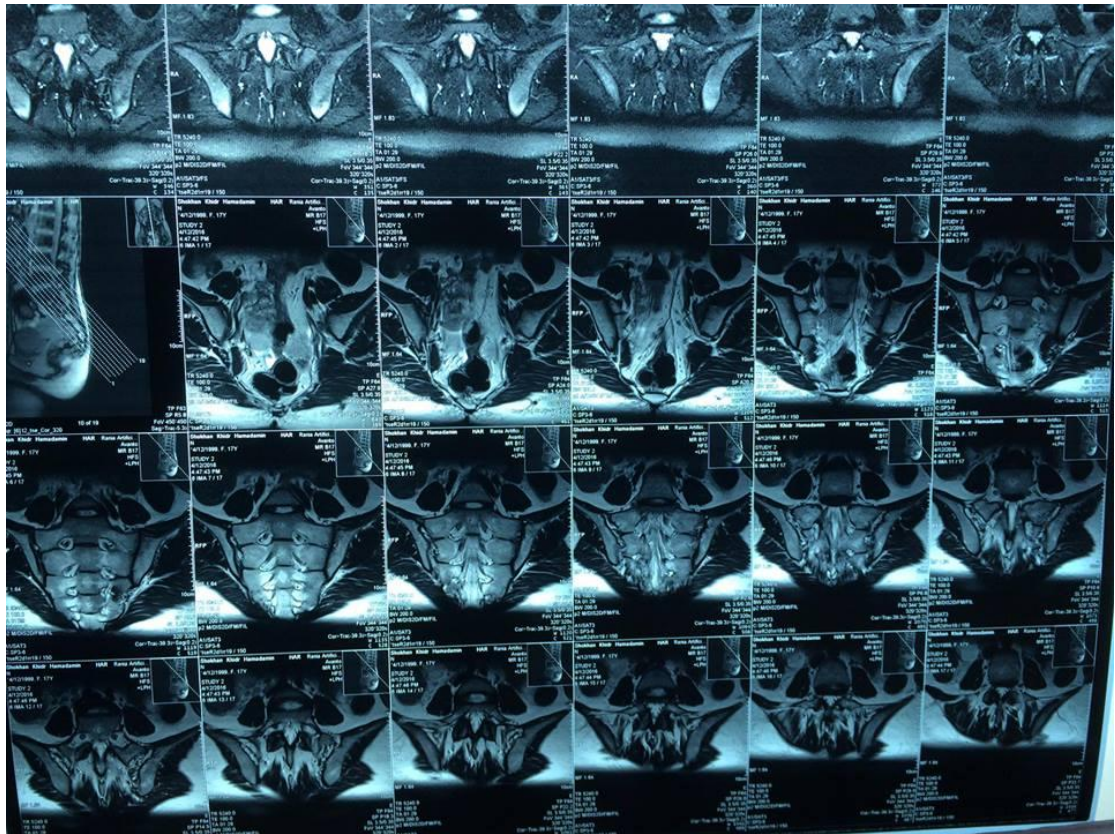
- Schoober test :negative
- SIJ tests : suspicious?
- ESR : 20 mm/hr
- CRP : negative

The MRI report says that there's evidence of bilateral Sacroiliitis?!

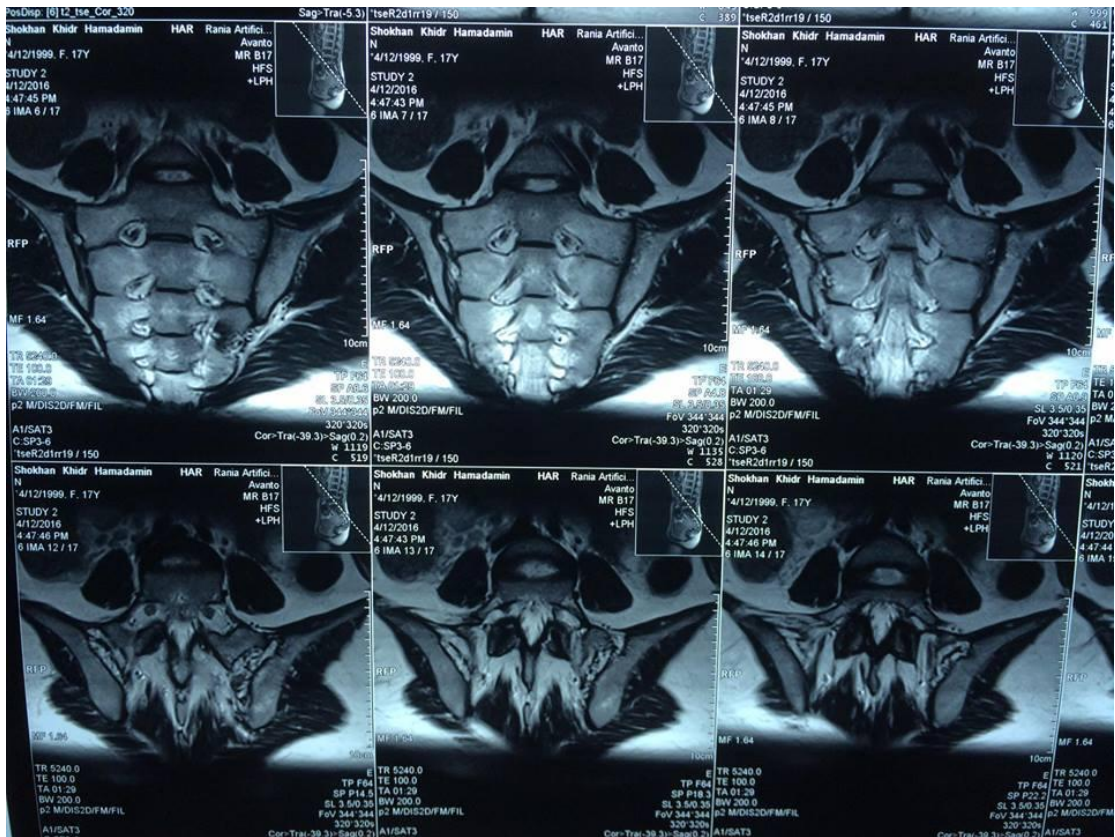
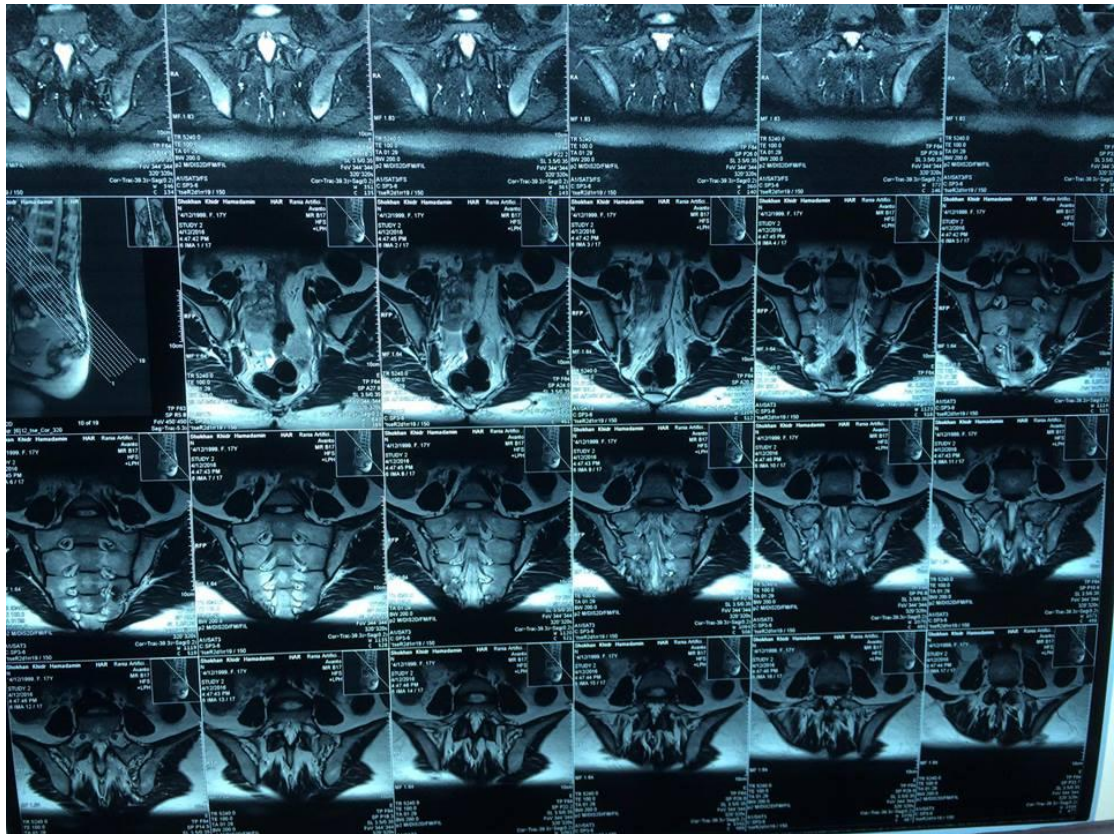
What's your opinions about the Report? Is there evidence of sacroiliitis?

Great Regards

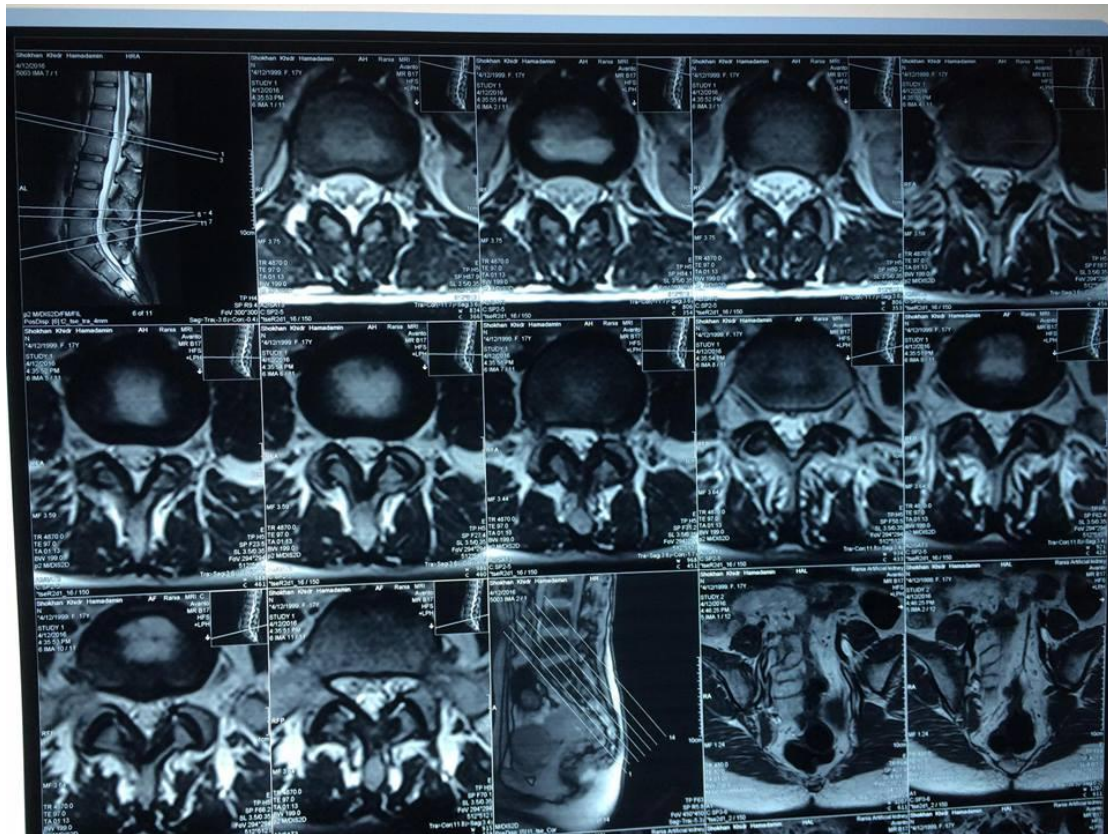












**Omer Mala Ahmed** Dear profs & Doctors  
**Bassel El-Zorkany**, **Howaida Elsayed Mansour**, **Tamer Elfarahaty**, **Mona Mansour**, **Rageh Elsayed**, **Mohammed Hassan**, **Sherry Kamel**, **Aliaa Omar El-hady**, **Samarino Helal**...

**Mohamed Magdy** What is the character of the LBP ???

Evidence of enthesitis , skin rash , inflammatory bowel or not

**Omer Mala Ahmed** Dear Dr **Mohamed Magdy**

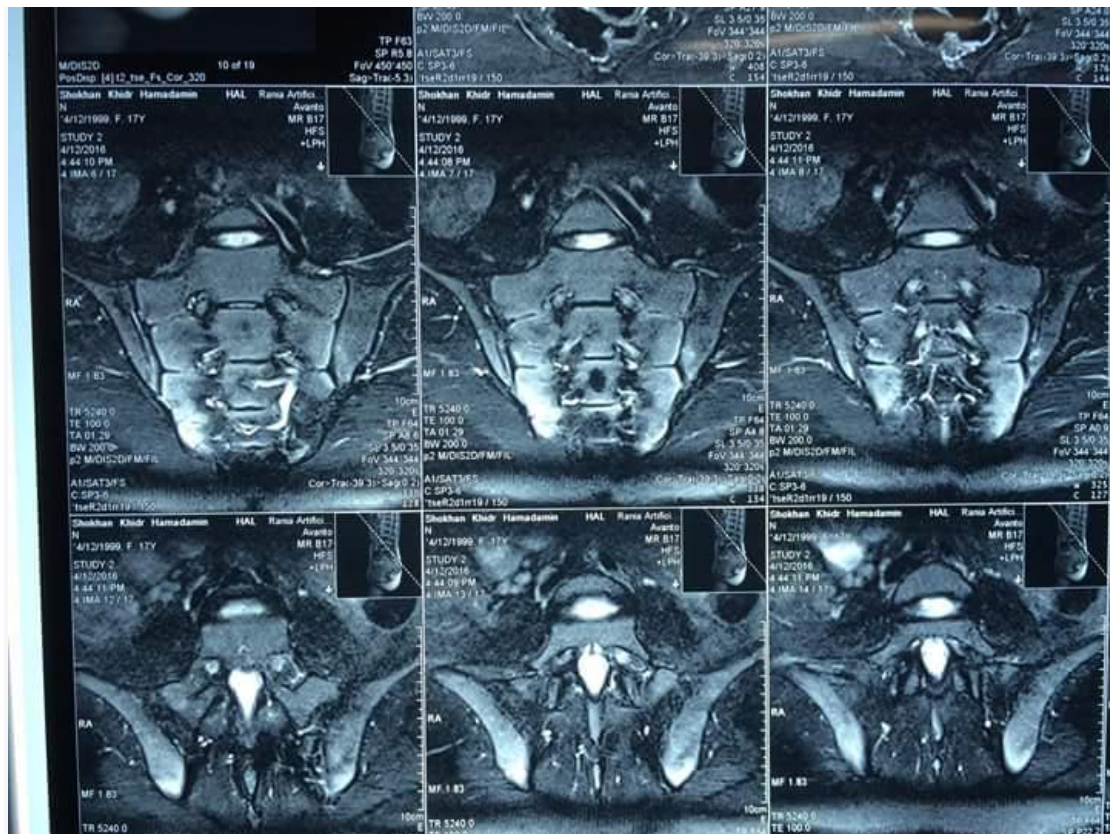
The back pain nearly constant, morning stiffness for few minutes, no skin rash or enthesitis or bowel problem

**Howaida Elsayed Mansour** It seems that she has bilateral sacroiliitis but more at one side, schober's test may be negative early bec the spine is Ok ...start regular NSAIDs for 4 weeks if no response you can change to another NSAID or start course of an anti TNF alpha...

**Nesreen Moustafa** Dr Omar I thought the radiologist did not do STIR view which shows us clearly if there is bone marrow edema or no what we see is T1 only I thought there is fatty degeneration but we are not sure of sacroiliitis

**Aliaa Omar El-hady**





**Sherry Kamel** Dear dr. what the character of LBP, it is inflammatory or mechanic??

Although MRI suspicious, but I prefer to give ur patient course of NSAIDs for 3\_6 months plus rehabilitation, physical modalities for relieving pain,

You can do local steroids injection in SIJ.....if patient don't respond to ur management, repeat MRI using STIR technique and re-evaluate ur patient before adding anti-TNF

**Bassel El-Zorkany** **Sherry Kamel**

Allow me to disagree. No consensus for anti TNF in this case currently and no consensus also for NSAID "for 3-6 months". I am afraid that people follow our empirical personal information. Thank you

**Sherry Kamel** Thanks ,dear prof. **Bassel El-Zorkany**. 😊😊🌹🌹..

🌹🌹 For your discussion,,but according to MRI finding , there is suspicious sacroilitis , so what I wrote, is the usual regimen not

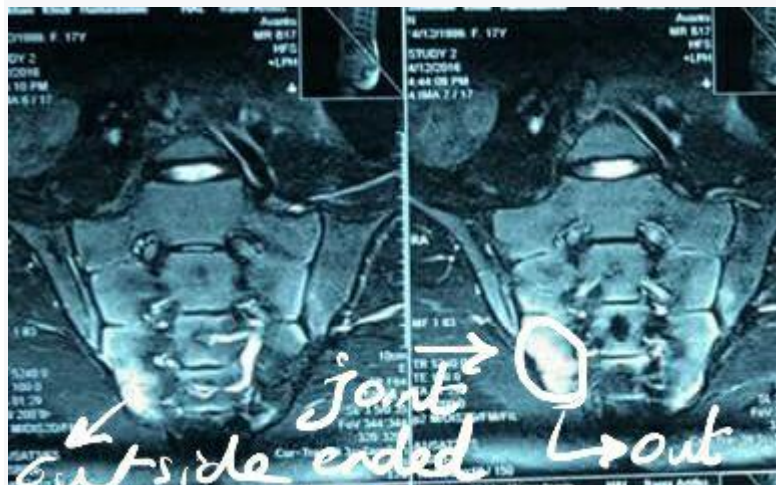
empirical ( using NSAIDs for 3\_6months then if no response we shift to anti-TNF ..) 😊😊, moreover I advice to repeat MRI using STIR technique and taking good history about the nature of LBP , does it inflammatory or mechanical.

Thanks 🌹🌹🌹🌹

[Aliaa Omar El-hady](#) Thanks Dr. [Omer Mala Ahmed](#) for sharing this nice case, I don't see any sure signs in MRI to diagnose it as sacroiliitis, please do Sacroiliac Mid Sagittal STIR MRI to confirm if it is inflammatory or a mechanical cause as prof. Dr. [Bassel El-Zorkany](#) told us.

[Bassel El-Zorkany](#) BMO signal is not "classic". Because it is exceeding the joint margin. More inferior. It can happen with a fissure for example. Measure vit.D and PTH and for a history of trauma even a minor fall on buttocks. Look carefully in the X rays and MRI

[Bassel El-Zorkany](#)



[Bassel El-Zorkany](#) Thank you Dr. [Aliaa Omar El-hady](#)



**Mohammed Hassan** good morning all dear profs,  
really i doubt if it's real sacroilitis ??  
plz dr SIJ MRI SAGITAL VIEW STIR technique  
totally agree with Profs **Bassel El-Zorkany** , **Aliaa Omar El-hady**  
**Tamer Elfarahaty** Dear dr omer , what is nature of LBP and its  
duration , duration of MS , other features of SPA ( Enthesitis ,  
uveitis,,,) .any specific finding of SPA like squaring ,  
syndesmophytes in lateral view of lumbosacral spine. i see  
narrowing of upper pole of rt hip with slight sclerosis in  
compare to left side . inflammation of SIJ inSPA is usually  
limited to the joint and not cross anatomical border as  
prof **Bassel El-Zorkany** mentioned . check vit D especially in  
such cases is helpful . if pain is inflammatory in origin, start full  
dose of NSADIs for 3 months, & Stretching Exc. and follow up  
clinically and by MRI . BME ( STIR view) is not static in AS  
and it can be changed by time ( ACR 2016) .

**Omer Mala Ahmed** Dear dr **Tamer Elfarahaty** really this  
patient has back pain which during all the day , but she has  
morning stiffness for few minutes just , no any other evidence of  
SPA

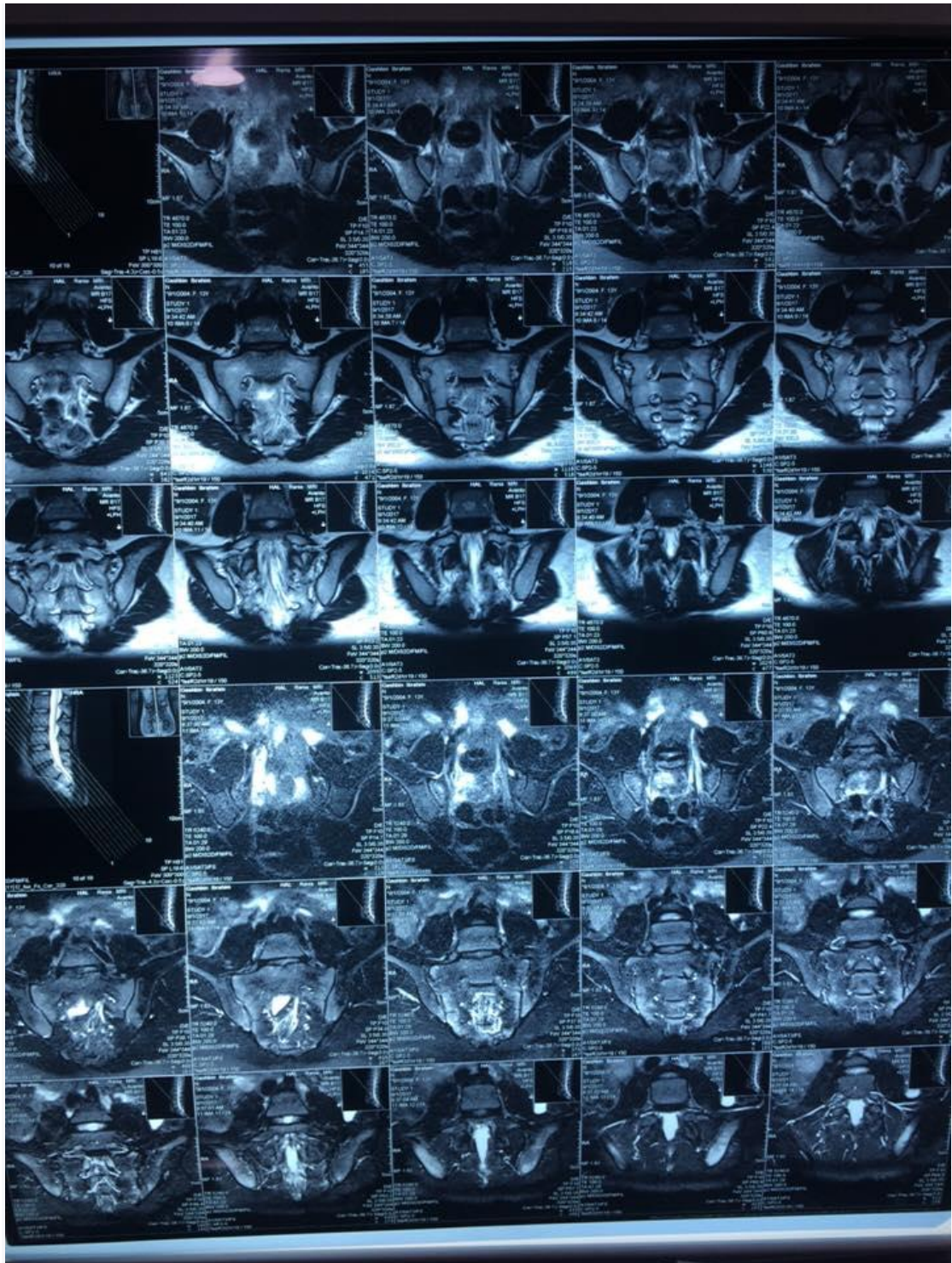
**Bassel El-Zorkany** Sorry **Sherry Kamel**. The recommended duration is 4 weeks in total for 1 OR 2 NSAID. If you used ASDAS with major change (delta 2.2, then continue ...) There is no mention for 3 to 6 months ... Anti TNF use with Negative CRP and ESR of 20 are not likely indicated .... The patient had already STIR made yet with BMO "NOT" SUGGESTIVE of SI ASSOCIATED WITH SpA. This sentence is usually frequently missed. I mean BMO is not absolute ... It should be suggesting SI OF SpA

**Sherry Kamel** Many thanks dear prof.for this informative and valuable comments.



**Omer Mala Ahmed** Dear profs & doctors  
**Bassel El-Zorkany**, **Howaida Elsayed Mansour**, **Sherry Kamel**, **Tamer Elfarahaty**, **Mohamed Magdy**, **Mohammed Hassan**, **Aliaa Omar El-hady**, Nesreen **Nesreen Moustafa**  
Thanks allot for your very valuable comments , while iam Busy about the result of this case , tomorrow another case just look alike this case came to me ( 14 years old lady with Low back pain & morning stiffness for 10-15 minutes, no other evidence of SPA , MRI revealed L5-S1 disc degeneration with the same findings in SIJs like this case .



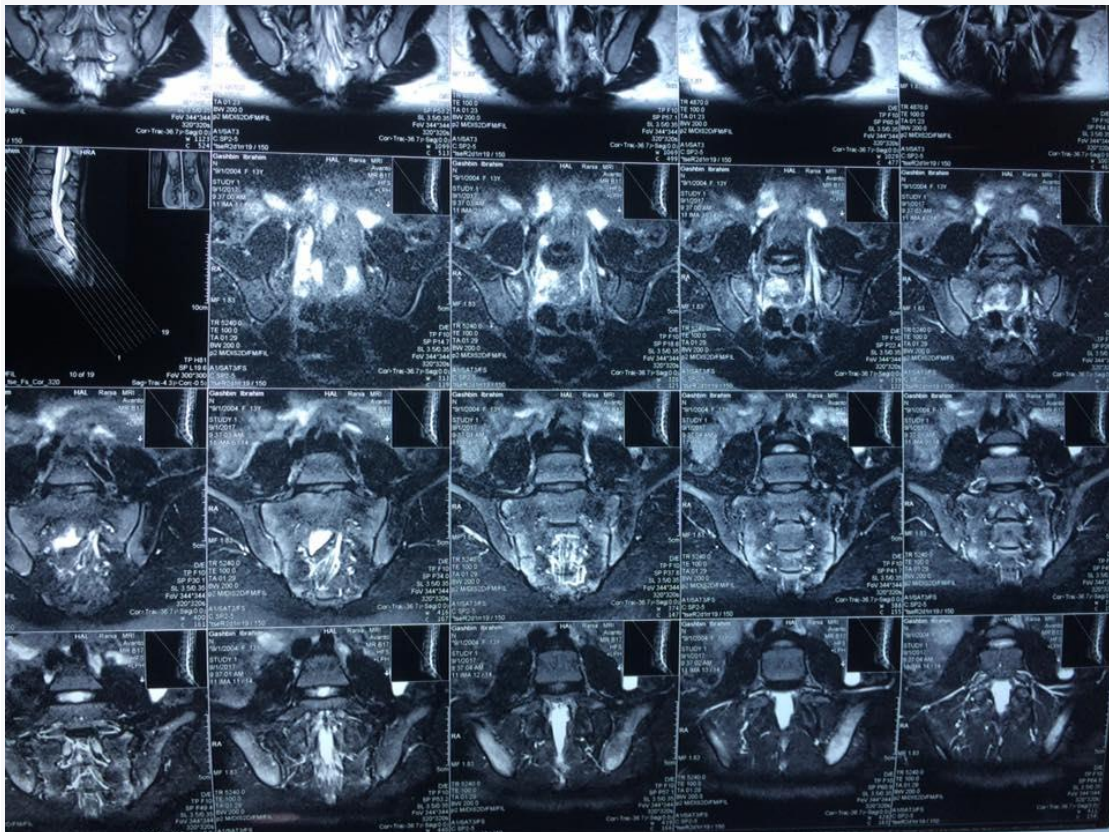


Omer Mala Ahmed

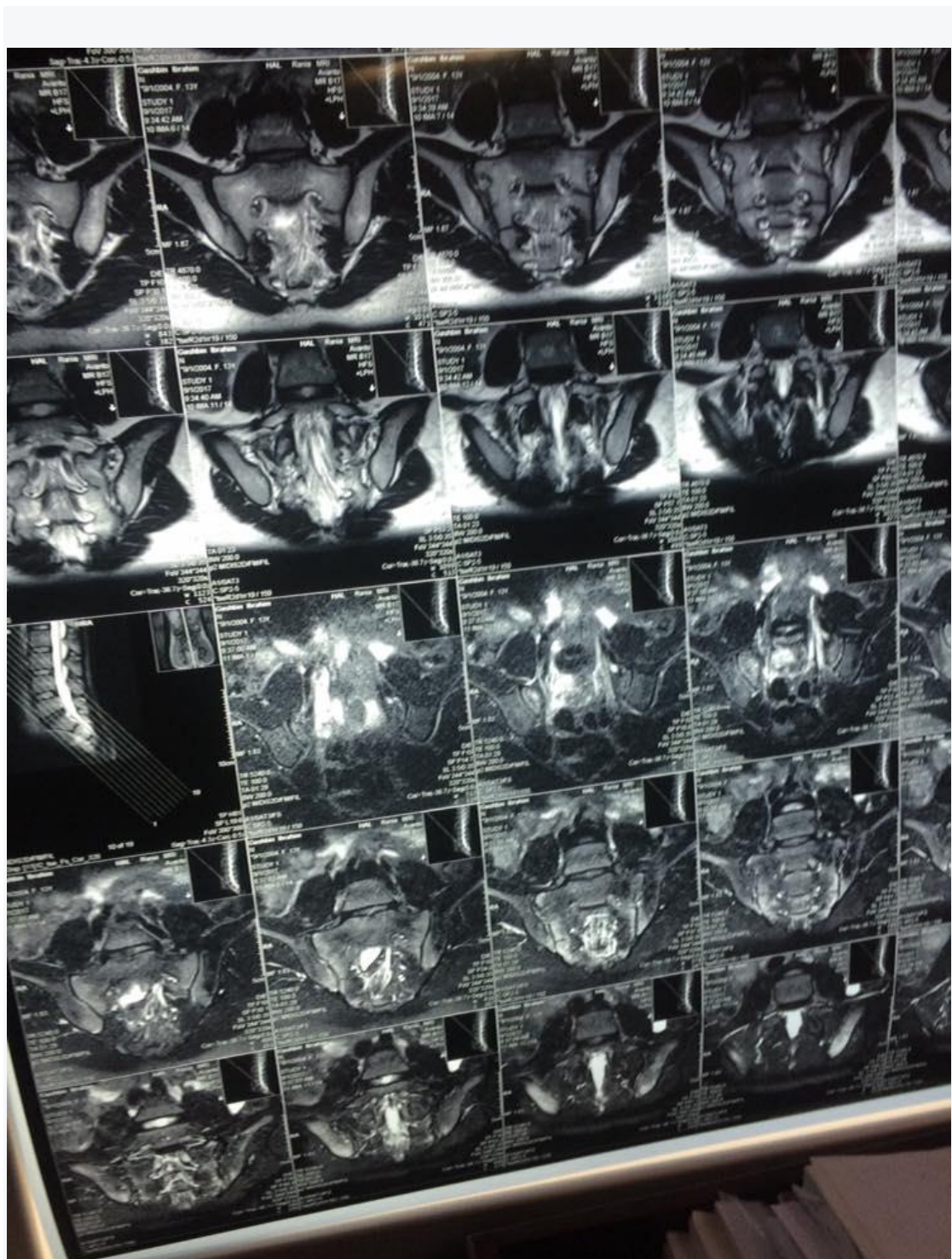




Omer Mala Ahmed

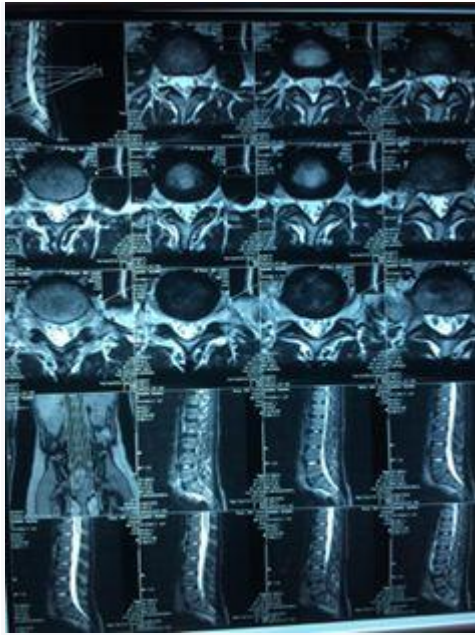


Omer Mala Ahmed

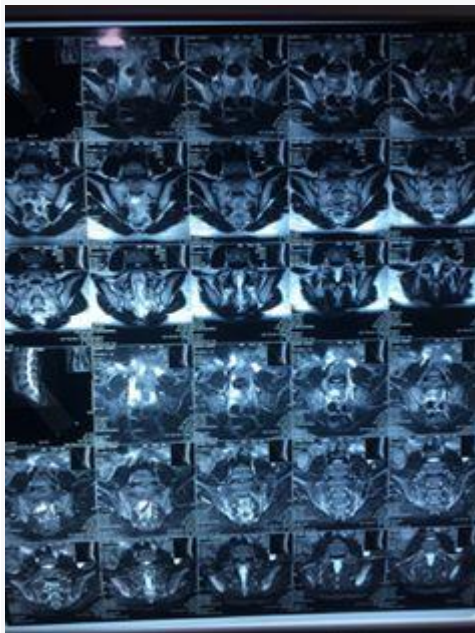


Omer Mala Ahmed





Omer Mala Ahmed



Omer Mala Ahmed



**Mohammed Hassan** What about nature of LBP?

**Omer Mala Ahmed** Dear Dr Mohammed the Back pain also the same of previous case , she has pain mainly during Flexion, sitting for long time, morning stiffness of 10-15 minutes, not

awake the patient from sleep. The pain increase with daily activities !

**Howaida Elsayed Mansour** Dear dr **Omer Mala Ahmed** it seems you are lucky these days...yes this lady likely has nr.axial SPA with lost lumbar loardosis with some squaring of the lumbar vertebrae and also sacroiliitis more at one side...is there any history of PsA (even isolated nail psoriasis) or any peripheral tenosynoviitis, unilateral knee / ankle arthritis ?

**Omer Mala Ahmed** Thanks allot dear prof **Howaida Elsayed Mansour** for your information

No personal or family evidence of Psoriasis, no peripheral enthesitis or tendinitis, no peripheral arthritis.

I thought the pain is from L5-S1 disc degeneration because the patient has degenerated disc at this level & the bright signals are extended beyond the joint borders just like previous case !!

**Howaida Elsayed Mansour** disc prolapse is very common finding and many cases of SPA are missed due to concomitant disc prolapse and we are waiting the opinion of dr. **Bassel El-Zorkany**

**Howaida Elsayed Mansour** What about CRP, ESR any uviitis ?

**Omer Mala Ahmed** ESR is normal ( 18 ) , CRP : low titer positive , no uveitis



**Howaida Elsayed Mansour** Start regular NSAIDs and keep an eye for any updates

**Omer Mala Ahmed** Thanks allot dear prof **Howaida Elsayed Mansour** for your always continuous supportive informations 🙌.